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MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

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MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM

MONDAY, FEBRUARY 14, 1983

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, D.C.

The subcommittee met at 10:05 a.m., pursuant to notice, in room B-318, Rayburn House Office Building, Hon. Andy Jacobs, Jr. (chairman of the subcommittee) presiding.

[Editor's note.—The administration presented testimony on the DRG system on February 3, 1983, in connection with hearings on recommendations of the National Commission on Social Security Reform. Those hearings are printed in Serial 98-3.]

[The press release announcing the hearing follows:]

[Press Release of Jan. 27, 1983]

Hon. Dan Rostenkowski (D., Ill.), Chairman, Committee on Ways and Means, Announces Full Committee and Subcommittee Hearings on the Medicare Hospital Prospective Payment System Proposed by the Administration

The Honorable Dan Rostenkowski (D., Ill.), Chairman of the Committee on Ways and Means, U.S. House of Representatives, today announced a series of hearings to be held by both the full Committee and the Subcommittee on Health to examine the Administration's medicare hospital prospective payment proposal.

The full Committee will begin the hearings on this topic with testimony from the Administration on February 3, 1983. Administration witnesses are already scheduled to testify before the Committee on that date, beginning at 9:00 a.m. in Room 1100 Longworth House Office Building, on financing problems of the social security system. The Committee has asked the Department of Health and Human Services to expand its testimony to include the topic of the Administration's medicare prospective payment proposal and its effect on the long-range medicare financing situation.

The Subcommittee on Health, chaired by the Honorable Andy Jacobs, Jr., (D., Ind.), will hear testimony on February 14 and 15, 1983, from individuals and organizations who have requested to be heard. The Subcommittee hearings will be held in Room B-318, Rayburn House Office Building, beginning at 10:00 a.m. each day.

The purpose of the hearings is to examine the prospective payment proposal forwarded to the Congress by the Department of Health and Human Services as required by Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD

Individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests to be heard by telephone to Harriett Lawler (telephone (202) 225-3627) no later than noon, Wednesday, February 9, 1983, to be followed by a formal written request to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. Notification to those scheduled to appear will be made by telephone as soon as possible after the filing deadline.

It is urged that persons and organizations having a common position make every effort to designate one spokesperson to represent them in order for the Subcommittee to hear as many points of view as possible. Time for oral presentations will be limited with the understanding that a more detailed statement may be included in the printed record of the hearings. This procedure will afford more time for members to question witnesses. In order to expedite the hearings, witnesses may be grouped as panelists with strict time limitations for each panelist.

Requests to be heard must contain the following information:

1. The name, full address, and capacity in which the witness will appear (as well as a telephone number where he or his designated representative may be reached);
2. A list of any clients or persons, or any organization for whom the witness appears; and
3. A topical outline or summary of comments and recommendations.

The above information should also be incorporated in the prepared statements to be presented in person as well as those for the written record of the hearing.

In order to assure the most productive use of the limited amount of time available to question witnesses, witnesses scheduled to appear before the Subcommittee are required to submit 50 copies of their prepared statement to the full Committee office, room 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearance.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, five copies are required and may be submitted to the Committee office by the close of business Monday, February 28, 1983. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Committee office before the hearing.

Chairman JACOBS. We will begin our hearings of the Health Subcommittee of the Ways and Means Committee of the House of Representatives. We have quite a list of witnesses and the Chair is not only going to have to ask but I am afraid to rule that the 5-minute rule will be strictly observed with two exceptions, and that is Members of Congress and the Congressional Budget Office. Only those exceptions.

We all think we are only speaking for 5 minutes when in fact we have spoken 50 minutes, so the Chair, without meaning to be impolite, will rap the gavel at the 5-minute mark. We will do that a little bit like the U.S. Supreme Court, right in midsyllable, that is the end of the statement.

On the other hand, the carrot is that the person who testifies most briefly, which is to say concisely today, will win $1 and the person who is the runner up will be awarded 50 cents.

So with that we recognize our good friend and colleague, Congressman Wyden of Oregon.

STATEMENT OF HON. RON WYDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WYDEN. Thank you very much, Mr. Chairman, I appreciate the chance to testify. It is no secret to you or other members of the Ways and Means Committee that I am in support of the prospective payment concept and I think it is no secret that at this time most of the experts agree that this is the way to go. This is the way to go to put a lid on out-of-control health-care spending and really at this point the issue is not whether we ought to have a prospective payment plan but how that plan ought to look, Mr. Chairman.

Now, as far as I know there are only two prospective payment plans that are on the table right now. First is the administration's proposal, diagnostic related grouping or DRG plan. And the second is my bill, H.R. 1227 on Medicare Payment Reform Act of 1983.

I am going to be very brief this morning. I will try and win that dollar, Mr. Chairman, but I would like to take a couple minutes and highlight the key differences between the approach that I am taking and the approach that the administration is taking.

The differences between the two approaches really fall in three areas. First, the administration does not allow States to develop their own prospective payment plans and my bill does.

Second, the administration's proposal doesn't cover all-payors and H.R. 1227 does.

Third, I think the administration's proposal is quite vague about protecting older consumers against cost shifting and dumping and in our bill we try to be specific in laying out consumer protections.

Let me go a little further on these three differences between the two approaches.

First, I think the most glaring omission of the administration's proposal is that it ignores the right of the States to create their own plan. I think that just doesn't make sense. Seven States and 30 municipalities have protective payment plans, and most, if not all, have been able to reduce the annual rate of increase in hospital costs from 2 percent to 6 percent below the national average. Of those, only New Jersey—the plan after which the administration is modeling its proposal—has a DRG prospective payment plan.

The evidence is compelling that the State approaches are working.

Maryland, which has a ratesetting commission prospective payment system, saw an increase in health-care costs during 1981 of only 15.6 percent. New York, which has a per diem system, saw an increase in costs of only 15.2 percent. And New Jersey, which has an all-payors DRG system, saw a rate of increase of only 11.4 percent. Yet, our national system saw an increase in costs of 17.7 percent.

The savings realized by the State plans are not to be sneezed at. And they prove one thing—States with varying types of prospective payment are able to keep costs down without sacrificing the quality of care.

Although the administration's report to Congress on hospital prospective payment plans is silent on the issue of keeping or creating State prospective payment plans, it acknowledges that most State prospective payment plans work, regardless of the type of plan.

For instance, it admits that Rhode Island, which has a statewide budget system for its 16 hospitals, has been able to realize savings under its plan. It also acknowledges that Maryland's hospitals are better off financially than they were before prospective payment, even though its plan is based on ratesetting on a hospital-by-hospital budget—not on the DRG system.

The facts speak for themselves—almost everywhere a prospective payment plan has been implemented there has been savings—and no two plans were exactly alike.

Mr. Chairman, second, in addition to being concerned about the lack of consideration for State flexibility in the administration's prospective payment plan, I am concerned about the exclusion of all-payor coverage.

I think the concept of all-payor coverage is critical, which was the thrust of Alice Rivlin's testimony last year. All-payor coverage recognizes that in order to win the war, we must do battle with all the sources of increased hospital costs—including medicaid and other third-party payors as well as medicare. Limiting coverage to medicare means that we will not get to the root of escalating health care costs.

My bill, unlike the administration's proposal, recognizes that cost shifting inflates the cost of private insurance plans, and that that means more costs for the patient, the insurance companies and the employer. In my State of Oregon alone during a 1-year period, third-party payors were forced to pay an additional $120 million in hospital costs due to cost overruns imposed by medicare, medicaid, bad debt, and charity care.

Without all-payors coverage in the prospective payment legislation we are likely to enact, these cost overruns will continue to increase in my State of Oregon and in the Nation as a whole. I think it is extremely shortsighted to force the taxpayers to shoulder an additional burden for health-care costs because the Federal Government does not want to bite the bullet and include all-payors coverage so we can do the job of controlling health care cost coverage right.

Mr. Chairman, I think it is also important to note that the administration's prospective payment plan covers only medicare, while the model that it is supposedly based on—New Jersey's—is an all-payors plan. The New Jersey program has worked well using the DRG setup, but there is no assurance that the administration's plan will work as well without the inclusion of all-payors coverage.

Finally, one last point, Mr. Chairman, I feel strongly that any prospective payment plan must explicitly protect patients against dumping and cost shifting. The administration's approach talks of monitoring these problems, but these consumer protections are so important that such vague commitments are inadequate. My bill clearly states that any prospective payment plan adopted by a State or the Federal Government has to specifically prohibit dumping or cost shifting.

With the Federal deficit at an alltime high, we cannot afford to make mistakes in revamping our health-care payment system. Each year, Americans are forced to pay more and more out-of-pocket expenses for health care. Each year, health-care costs take up a bigger and bigger chunk of the consumer price index. In 1960, health-care costs accounted for only 5 percent of GNP, while today they take up 10 percent. Obviously, if we are going to headoff continued inflation in health-care costs, it is critical that prospective payment legislation be done right.

In conclusion, Mr. Chairman, I would like to say that even though these hearings are on medicare, not social security, hearings, I would like to say that I think it would be good public policy if the key prospective payment reforms of medicare could be made part of the social security package that Congress will consider this spring. To adequately address the problems of social security, we must address the problems of medicare, social security's health care arm. I realize that is a lot of complicated legislation to bite off in one bill, but I think that Congress and the country will be better off if we do it together and do it together this spring.

Thank you for having me, Mr. Chairman and members of the committee.

[The prepared statement follows:]

STATEMENT OF HON. RON WYDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. Chairman and members of the committee, thank you for allowing me to testify today.

By now, it's no secret to members of the Ways and Means Committee—Ron Wyden likes prospective payment.

It's also no secret that most experts agree that prospective payment is the way to go to begin putting a lid on out-of-control health care spending.

At this point, the issue is not whether a prospective payment plan will be developed but how that plan should look.

As far as I know, there are only two prospective payment plans on the table at this time. The first is the Administration's Diagnostic Related Grouping, or DRG plan. The second is my prospective payment plan, H.R. 1227, the Medicare Payment Reform Act of 1983.

I will be brief this morning, but I'd like to take a few minutes and highlight the key differences between the two approaches. These differences fall in three areas. First, the Administration's plan does not allow states to develop their own prospective payment plans, and my bill does. Second, the Administration's proposal does not cover all-payors, and my bill does. Third, the Administration's plan is very vague about protecting older consumers against cost-shifting and dumping, and my bill is specific in laying out these consumer protections. I'll expand on each of these three differences.

The most glaring omission of the Administration's plan is that it ignores the right of states to create their own plans.

That just doesn't make sense.

Seven states and 30 municipalities have prospective payment plans, and most, if not all, have been able to reduce the annual rate of increase in hospital costs from 2 percent to 6 percent below the national average. Of those, only New Jersey—the plan after which the Administration is modeling its proposal—has a DRG prospective payment plan.

The evidence is compelling.

Maryland, which has a rate setting commission prospective payment system, saw an increase in health care costs during 1981 of only 15.6 percent. New York, which has a per diem system, saw an increase in health care costs during 1981 of only 15.6 percent. New York, which has a per diem system, saw an increase in costs of only 15.2 percent. And New Jersey, which has an all-payors DRG system, saw a rate of increase of only 11.4 percent. Yet, our national system saw an increase in costs of a whopping 17.7 percent.

The savings realized by the state plans are not to be sneezed at. And they prove one thing—states with varying types of prospective payment are able to keep costs down without sacrificing the quality of care.

Although the Administration's Report to Congress on Hospital Prospective Payment plans is silent on the issue of keeping or creating state prospective payment plans, it acknowledges that most state prospective payment plans work, regardless of the type of plan.

For instance, it admits that Rhode Island, which has a statewide budget system for its 16 hospitals, has been able to realize savings under its plan. It also acknowledges that Maryland's hospitals appear to be better off financially than they were before prospective payment, even though its plan is based on rate setting on a hospital-by-hospital budget—not on DRGs.

The facts speak for themselves—almost everywhere a prospective payment plan has been implemented there has been savings—and no two plans were exactly alike.

In addition to being concerned about the lack of consideration for state flexibility in the Administration's prospective payment plan, I am concerned about the exclusion of all-payor coverage.

The concept of all-payor coverage is critical as Alice Rivlin, Director of the Congressional Budget Office, said at a hearing late last year. All-payor coverage recognizes that in order to win the war, we must do battle with all the sources of increased hospital costs—including Medicaid and other third-pary payors as well as Medicare. Limiting coverage to Medicare means that we will not get to the root of escalating health care costs.

My bill, unlike the Administration's proposal, recognizes that cost-shifting inflates the cost of private insurance plans, and that that means more costs for the patient, the insurance companies and the employer. In my State alone during a one-year period, third-party payors were forced to pay an additional $120 million in hospital costs due to cost overruns imposed by Medicare, Medicaid, bad debt and charity care.

Without all-payors coverage in the prospective payment legislation we are likely to enact, these cost-overruns will continue to increase in Oregon and in the nation as a whole. I think it's extremely shortsighted to force the taxpayers to shoulder an additional burden for health care costs because the federal government does not want to bite the bullet and include all-payors coverage so we can do the job right.

I think it's also important to note that the Administration's prospective payment plan covers only Medicare, while the model that it is supposedly based on—New Jersey's—is an all-payors plan. The New Jersey program has worked well using the DRG set-up, but there is no assurance that the Administration's plan will work as well without the inclusion of all-payors coverage.

Finally, I feel strongly that any prospective payment plan must explicitly protect patients against dumping and cost-shifting. The Administration's approach talks of "monitoring" these problems, but these consumer protections are so important that such vague commitments are inadequate. My bill clearly states that any prospective payment plan adopted by a state or the federal government must specifically prohibit dumping or cost-shifting.

With the federal deficit at an all-time high, we cannot afford to make mistakes in revamping our health care payment system. Each year, Americans are forced to pay more and more out-of-pocket expenses for health care. Each year, health care costs take up a bigger and bigger chunk of the consumer price index. In 1960, health care costs accounted for only 5 percent of GNP, while today they take up 10 percent. Obviously, if we are going to head-off continued inflation in health care costs, it's critical that prospective payment legislation be done right.

I'd like to make one last point, Mr. Chairman. Even though these are Medicare, not Social Security, hearings, I would like to say that I think it would be good public policy if the key prospective payment reforms of Medicare could be made part of the Social Security package that Congress will consider this Spring. To adequately address the problems of Social Security, we must address the problems of Medicare—Social Security's health care arm. I realize that's a lot of complicated legislation to bite off in one bill, but I think that Congress and the country will be better off if we do.

Chairman JACOBS. Thank you.

Mr. Moore.

Mr. MOORE. No questions, Mr. Chairman. Thank you.

Chairman JACOBS. Mr. Duncan.

Mr. DUNCAN. I have no questions, Mr. Chairman.

Chairman JACOBS. The committee thanks you.

If someone around here works harder than you I don't know who it is and especially in this area, and we are grateful for your contribution, especially for drafting the bill with different features from the administration's bill. Makes us feel important, we have something to choose between.

Mr. WYDEN. Thank you, Mr. Chairman. I would only want to say thank you to the staff of the Ways and Means Health Subcommittee as well. They have been very helpful in drafting this bill. Thank you very much.

Chairman JACOBS. The Congressional Budget Office, Nancy Gordon, Assistant Director for Human Resources and Community Development.

Welcome to the committee, Dr. Gordon.

STATEMENT OF NANCY M. GORDON, ASSISTANT DIRECTOR FOR HUMAN RESOURCES AND COMMUNITY DEVELOPMENT, CONGRESSIONAL BUDGET OFFICE, ACCOMPANIED BY PAUL GINSBURG, DEPUTY ASSISTANT DIRECTOR; AND LISA POTETZ, ANALYST

Ms. GORDON. Thank you. I don't think I will be in the running to win your dollar prize, but I will shorten the statement from the written version somewhat.

Chairman JACOBS. Any port in a storm.

Ms. GORDON. With me today are Paul Ginsburg, my deputy for income security and health, and Lisa Potetz, our hospital reimbursement analyst.

The rapid rise in medicare payments to the hospitals that we have just heard about has been of major concern in recent years. TEFRA took a first step in lowering these costs. As directed in TEFRA, the administration has submitted a full-fledged prospective payment plan. My testimony briefly describes their plan and then discusses its particular effects on hospitals, beneficiaries, and the Federal budget.

I am sure you are familiar with the administration's DRG [diagnostic-related group] plan, so I will skip our description of that and go directly to its advantages.

First, it would reduce growth in overall hospital costs by increasing hospitals' incentives to reduce costs. Bonuses to hospitals that keep costs below reimbursement levels would not be limited; that is, they could keep the entire difference between their costs and their reimbursements whereas under TEFRA they keep only a portion of the difference.

Second, by not basing payment on each hospital's previous costs, it would avoid the problem of paying more to relatively less efficient hospitals.

Third, because payment would be based on diagnosis, the system would take account of differences in the mix of patients and in their costliness, both among hospitals and within each hospital over time.

Finally, by identifying services for which costs are relatively high in a hospital, the DRG system could be a valuable internal management tool enabling hospitals and physicians to find ways to lower costs without reducing the quality of care.

Despite its advantages, however, the proposal has certain drawbacks. First, because it would cover only medicare, cost reductions would be more limited than if all other payors including private health plans were covered.

Moreover, as under TEFRA, hospitals would be able to make up part of the reduction in their reimbursements from medicare by raising charges to private patients.

Second, the administration's proposal would radically change the system of hospital reimbursements on the basis of a methodology that has not been tested and that at present appears insufficiently refined. The proposed sudden transition from the cost-reimbursement system which is heavily based on hospital-specific costs, to one based entirely on DRG's would mean that some hospitals would receive payments greatly in excess of costs while others would incur substantial losses.

Such major shifts might be justified if there were reason to believe that the bonuses would go to relatively efficient hospitals and the penalties to inefficient ones. But the Congressional Budget Office analysis described below raises serious doubts about the sensitivity of the proposed DRG system to actual differences in the cost of treating different types of patients.

Individual hospitals would experience large changes in their reimbursements under the administration's specific DRG proposal. Our preliminary analysis indicates that approximately 34 percent of hospitals would have reimbursements at least 25 percent higher than under TEFRA while 4 percent would have reimbursements at least 25 percent lower.

The proposal would also have very uneven effects on different types of hospitals. For example, small hospitals would do much better than large ones and rural hospitals much better than urban. As shown in table 1 of my statement, hospitals with less than 100 beds would as a group receive a 25-percent increase in reimbursement from levels under TEFRA, while those with over 300 beds would face a 6-percent reduction. Hospitals in rural areas would gain 19 percent as a group, whereas urban hospitals would lose 4 percent.

Several factors may contribute to these disparities among groups of hospitals. First, hospitals that are small or in rural areas may serve patients who tend to be less severely ill than the average in a particular DRG. Second, the adjustment for geographic wage differences may not be sufficient to correct for actual differences in operating costs between urban and rural areas. Finally, regional variation may reflect differences in patterns of practice.

Medicare beneficiaries could also experience reduced access to quality care under the administration's proposal, a risk that exists under TEFRA limits as well. One reason for this is that, if hospitals face lower payments, they might respond by admitting fewer medicare patients, particularly those most costly to treat. Moreover, some hospitals with a large proportion of medicare patients might experience serious financial problems and be forced to postpone modernization or to close. These problems would become more serious if payment levels were tightened over time, thereby widening the differences between payment for medicare patients and private patients.

In examining the budget impact of the administration's proposal, two distinct periods must be considered: the 1984–85 period when the proposal would replace current reimbursement limits enacted as part of TEFRA, and later years when the growth rate limitations under TEFRA would have expired.

The Congressional Budget Office cannot at this time estimate the 1984–85 budget impacts of this proposal because key details such as the base reimbursement level and the rate at which it would increase over time have not been specified. The administration has made it clear, however, that it intends total medicare reimbursement to be the same as under current law.

Achieving this budget neutrality would be technically complex but possible. For example, since both the TEFRA reimbursement limits and DRG-based payments imply reimbursements far below allowable costs for some hospitals, the appeals policy would be an important determinant of total reimbursements.

In addition, changes in hospital behavior would occur in response to the new reimbursement policies. These would affect Federal outlays in a number of ways that would have to be taken into account when setting the base-reimbursement level.

For one, hospitals would have an incentive to admit more patients whose need for in-patient care was marginal, although they would gain less from such behavior than under the TEFRA limits because the DRG reimbursements would reflect the costliness of the diagnosis. Also, some analysts have raised the prospect of DRG creep, that is, a tendency for patients with chronic illnesses or multiple diagnoses to be placed in the most expensive DRG's. This effect would probably be small, though, because the diagnostic categories have been designed to make this difficult and because the utilization review by medicare intermediaries proposed by the administration could identify some of these cases.

For 1986 and beyond the Congress would have to decide upon a goal for budget savings. It could direct that reimbursements be set to continue the level of stringency in the third year of TEFRA, that is, about 9 percent below what reimbursements would have been under pre-TEFRA policies, or it could tighten reimbursements further in each successive year. Successive tightening of reimbursements, for example, by continuing the TEFRA growth rate formula that uses the increase in the cost of the hospital market basket plus 1 percentage point, would cut Federal outlays substantially but at the risk of reducing beneficiaries' access to quality care.

The nature of this potential trade-off would depend on the extent to which hospitals responded to lower reimbursements by cutting costs rather than by raising charges to private patients. The smaller the eventual difference between the medicare reimbursement and private reimbursement, the smaller the reduction in access for beneficiaries.

While the administration's proposal would ease the long-range financing problems of medicare somewhat by cutting reimbursements from 1986 on, serious financial problems would remain. Under current law the HI trust fund is projected to be exhausted by 1987. If the administration's proposal continued the projected 1985 degree of reimbursement stringency, exhaustion would be delayed only until 1988. Successive tightening year after year at the same rate as under TEFRA would postpone exhaustion until 1989.

In conclusion, any prospective payment system would offer hospitals greater incentives to reduce costs than exist under TEFRA, and the administration's DRG approach has important advantages over other prospective payment plans. Most importantly, it would not build in inefficiencies that now exist in some hospitals. On the other hand, the specific design of its proposal would lead to a substantial reallocation of medicare payments among hospitals that would not reflect merely differences in efficiency.

A number of options are available that would address the proposal's shortcomings. For example, adjusting the payment level to take more account of variation in costs between urban and rural areas, or among regions, would reduce the systematic differences in impact by group.

The reallocation would also be less traumatic if it went into effect more gradually. One phase-in method would average a hospital's reimbursement under the DRG system with that under the current system of TEFRA limits, with the DRG payment being given increasing weight over time. Although administratively more complex, this approach would allow additional refinements in the DRG system on the basis of experience and further research before a complete transition was made.

Thank you, Mr. Chairman. That concludes my statement. I would be pleased to answer any questions.

[The prepared statement follows:]

STATEMENT OF NANCY M. GORDON, ASSISTANT DIRECTOR FOR HUMAN RESOURCES AND COMMUNITY DEVELOPMENT, CONGRESSIONAL BUDGET OFFICE

The rapid rise of Medicare payments to hospitals has been of major concern in recent years. These increases, averaging 18 percent annually between 1970 and 1982, add to the size of the budget deficit and threaten the solvency of the Hospital Insurance (HI) Trust Fund.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) sought to reduce Medicare outlays and to provide hospitals with incentives to bring costs down—incentives that had been absent under the system of retrospective cost-based reimbursement. To this end, TEFRA established limits on reimbursement. Relatively costly hospitals, and those with relatively high rates of cost growth, get lower reimbursement under TEFRA. Hospitals that have costs lower than their reimbursement limits receive a small bonus payment.

The Congress intended these changes as a first step toward a system of prospective reimbursement of hospitals under Medicare. Now, as directed in TEFRA, the Administration has submitted its proposal for a full-fledged prospective reimbursement system.

My testimony will begin with an overview of the Administration's proposal, and then discuss more specifically its potential effects—on hospitals, on beneficiaries, and on the federal budget.

OVERVIEW OF THE ADMINISTRATION'S PROPOSAL

The Administration has proposed for Medicare a system of prospective payments to hospitals based on Diagnostic Related Groups (DRGs). Under this system, a national payment level would be determined for each of 467 diagnostic groups that are relevant to the elderly and disabled. Except for adjustments to reflect geographic differences in wage levels, every hospital would face the same rate for each diagnosis. Additional payments would be made for unusually costly cases, and for the indirect costs associated with graduate medical education and nurse training programs.

The Administration's plan would work to reduce growth in overall hospital costs. Evidence from state programs that effect all third-party payers of medical care expenses indicates that prospective reimbursement has been successful there—the seven states with cost control programs in conformance with the 1981 reconciliation act experienced an 11 percent annual rise in costs between 1976 and 1981, compared to 14 percent for other states.[1]

As with other full-fledged prospective payment plans, the Administration's plan would increase hospitals' incentives to reduce costs. Bonuses to hospitals that keep costs below their reimbursement levels would not be limited—that is, they could keep the entire difference between their costs and their reimbursements, whereas under TEFRA they keep only a portion of the difference.

In addition, the Administration's proposal offers three potential advantages over other prospective payment methods. First, by not basing payment on each hospital's previous costs, it would avoid the problem of paying more to relatively less efficient hospitals. Second, because payment would be based on diagnosis, the system would take account of differences in the mix of patients and in their costliness—both among hospitals and within each hospital over time. Third, the DRG system, by identifying services for which costs are relatively high in a hospital, could be a valuable internal management tool, enabling hospitals and physicians to find ways to lower costs without reducing the quality of care.

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[1] The comparison is for per capita inpatient hospital costs reported in the American Hospital Association's Annual Survey.

Despite its advantages, the proposal has certain drawbacks. First, because it would cover only Medicare, cost reductions would be more limited than if all other payers, including private health plans, were covered. Moreover, as under TEFRA, hospitals would be able to make up part of the reduction in their reimbursement from Medicare by raising charges to private payers.

Second, the Administration's proposal would radically change the system of hospital reimbursements on the basis of a methodology that has not been tested and that at present appears to be insufficiently refined. The proposed sudden transition from the current reimbursement system—which is based heavily on hospital-specific costs—to one based entirely on DRGs would mean that some hospitals would receive payments greatly in excess of their costs and others would incur substantial losses. Such major shifts might be justified if there were reason to believe that the bonuses would go to relatively efficient hospitals, and the penalties to inefficient ones. But the Congressional Budget Office analysis discussed below raises serious doubts about the sensitivity of the proposed DRG system to actual differences in the cost of treating different types of patients.

Another reason for caution is the limited experience with DRGs to date. New Jersey is the only state that has based reimbursement on DRGs, and its system places less emphasis on them than would the Administration proposal. In New Jersey, payment for each DRG is a blend of the individual hospital's incurred costs for patients in that category and the average among all hospitals. Moreover, the particular set of DRGs that the Administration proposes to use is new and has only recently been employed to determine reimbursement rates. Studies of this system are underway, but conclusive results will not be available for some time.

EFFECTS OF THE ADMINISTRATION'S PROPOSAL ON HOSPITALS

Individual hospitals would experience large changes in their reimbursements under the Administration's specific DRG proposal. Preliminary analysis indicates that approximately 34 percent of hospitals would have reimbursements at least 25 percent higher than under TEFRA, while 4 percent would have reimbursements at least 25 percent lower.

The proposal would have very uneven effects on different types of hospitals as well—for example, small hospitals would do much better than large ones, and rural hospitals much better than urban hospitals. As shown in Table 1, hospitals with less than 100 beds would, as a group, receive a 23 percent increase in reimbursement from levels under TEFRA, while those with over 300 beds would face a 6 percent reduction. Hospitals in rural areas would gain 19 percent as a group, whereas urban hospitals would lose 4 percent.

TABLE 1.—ESTIMATED AVERAGE PENALTIES AND BONUSES UNDER THE ADMINISTRATION'S PROPOSED DRG-BASED PAYMENT SYSTEM, BY TYPE OF HOSPITAL[1]

	All hospitals		Hospitals that would gain		Hospitals that would lose	
	Percent distribution of hospitals	Aggregate effect as percent of reimbursements[2]	Percent distribution of hospitals	Aggregate effect as percent of reimbursements[3]	Percent distribution of hospitals	Aggregate effect as percent of reimbursements[4]
All hospitals	100	[5]0	61	+23	39	−12
Bed size:						
Less than 100	49	+23	80	+35	20	−10
100 to 299	34	+2	50	+21	50	−11
300 plus	17	−6	30	+17	70	−13
SMSA:						
SMSA	52	−4	43	+20	57	−13
Non-SMSA	48	+19	81	+29	19	−6
Region:						
Northeast	15	−4	45	+19	55	−12
North Central	28	−4	60	+21	40	−13
South	37	+8	72	+26	28	−9
West	20	−2	57	+23	43	−13

TABLE 1.—ESTIMATED AVERAGE PENALTIES AND BONUSES UNDER THE ADMINISTRATION'S PROPOSED DRG-BASED PAYMENT SYSTEM, BY TYPE OF HOSPITAL[1]—Continued

	All hospitals		Hospitals that would gain		Hospitals that would lose	
	Percent distribution of hospitals	Aggregate effect as percent of reimbursements[2]	Percent distribution of hospitals	Aggregate effect as percent of reimbursements[3]	Percent distribution of hospitals	Aggregate effect as percent of reimbursements[4]
Teaching status:						
Teaching	18	−7	29	+18	71	−13
Nonteaching	82	+7	69	+24	32	−10
Ownership:						
Nonprofit	57	−2	55	+20	45	−12
Government	31	+9	78	+29	22	−12
Proprietary	12	−1	48	+22	52	−13

[1] Assumes an average payment level needed to keep outlays at the same level as under TEFRA in fiscal year 1984. Average gains and losses are incremental to those under TEFRA, which are assumed to be the average for each group. Effects of phase-in and adjustments for exceptionally costly cases are excluded, but an adjustment for teaching hospitals is included.

[2] Average calculated for all hospitals.

[3] Average calculated for hospitals that would gain.

[4] Average calculated for hospitals that would lose.

[5] Because aggregate reimbursements were assumed to be the same as under TEFRA, increases in payments to some hospitals would be exactly offset by decreased payments to others.

Source: Preliminary CBO estimates based on medicare cost reports for 1980.

Several factors may contribute to these disparities among groups of hospitals. First, hospitals that are small or in rural areas may serve patients who tend to be less severely ill than the average in a particular DRG. Second, the adjustment for geographic wage differentials may not be sufficient to correct for all differences in operating costs between urban and rural areas. Finally, the regional variation may reflect differences in patterns of practice.

Even if a more refined DRG system was developed, individual hospitals might still receive unwarranted bonuses or penalties. To the extent that a hospital treated patients who were more or less costly than the average for a DRG, it would lose or gain accordingly. The fewer Medicare cases in a hospital, the greater the chance that random variation of this sort would produce unwarranted effects, although the total impact on the hospital would be small.

EFFECTS OF THE ADMINISTRATION'S PROPOSAL ON MEDICARE BENEFICIARIES

Medicare beneficiaries could experience reduced access to quality care under the Administration's proposal—a risk that exists under the TEFRA limits as well.

One reason for this is that if hospitals faced lower payments they might respond by admitting fewer Medicare patients—particularly those most costly to treat. Moreover, some hospitals with a large proportion of Medicare patients might experience serious financial problems and be forced to postpone modernization or to close. These problems would become more serious if payment levels were tightened over time, thereby widening the distance between payment for Medicare patients and private patients.

Access might also be reduced if hospitals responded to the DRG system by specializing in particular services. A hospital might decide to eliminate a particular service if the payment level was too low compared to its average cost of treatment. If this was because the relative payment level had been set incorrectly, other hospitals might not be anxious to meet the demand for that service either, so that a whole area might experience access problems.

On the other hand, increased specialization of services might improve the quality of care in some circumstances. Studies have shown that the health outcomes for some difficult procedures are best when they are performed in hospitals that perform them frequently. These types of procedures might not be the only services cut back, however.

EFFECTS OF ADMINISTRATION'S PROPOSAL ON THE FEDERAL BUDGET

In examining the budget impact of the Administration's proposal, two distinct periods must be considered—the 1984-1985 period, when the proposal would replace current reimbursement limits enacted as part of TEFRA, and later years when the growth-rate limitations under TEFRA would have expired.

The Congressional Budget Office cannot at this time estimate the 1984-1985 budget impacts of this proposal because key details, such as the base reimbursement level and the rate at which it would increase over time, have not been specified. The Administration has made it clear, however, that it intends total Medicare reimbursements to be the same as under current law.

Achieving this budget neutrality would be technically complex, but possible. For example, since both the TEFRA reimbursement limits and the DRG-based payments imply reimbursements far below allowable costs for some hospitals, the appeals policy would be an important determinant of total reimbursements.

In addition, changes in hospital behavior would occur in response to the new reimbursement policies. These would affect federal outlays in a number of ways that would have to be taken into account when setting the base reimbursement level. For one, hospitals would have an incentive to admit more patients whose need for inpatient care was marginal, although they would gain less from such behavior than under the TEFRA limits, because the DRG reimbursements would reflect the costliness of the diagnosis. Also, some analysts have raised the prospect of DRG "creep"—that is, a tendency for patients with chronic illnesses or multiple diagnoses to be placed in the most expensive DRGs. This effect would probably be small, though, because the diagnostic categories have been designed to make this difficult and because the utilization review by Medicare intermediaries proposed by the Administration could identify some of these cases.

For 1986 and beyond, the Congress would have to decide upon a goal for budget savings. It could direct that reimbursements be set to continue the level of stringency in the third year of TEFRA—that is, about 9 percent below what reimbursements would have been under pre-TEFRA policies—or it could tighten reimbursements further in each successive year.

Successive tightening of reimbursements—for example, by continuing the TEFRA growth rate formula that uses the increase in the cost of the hospital market basket plus one percentage point—would cut federal outlays substantially, but at the risk of reducing beneficiaries' access to quality care. The nature of this potential tradeoff would depend on the extent to which hospitals responded to lower reimbursements by cutting costs rather than by raising charges to private patients. The smaller the eventual difference between the Medicare reimbursement and private reimbursement, the smaller the reduction in access for Medicare beneficiaries.

While the Administration's proposal would ease the long-range financing problems of Medicare somewhat by cutting reimbursements from 1986 on, serious financial problems would remain. Under current law, the HI trust fund is projected to be exhausted by 1987.[2] If the Administration's proposal continued the projected 1985 degree of reimbursement stringency, exhaustion would be delayed only until 1988. Successive tightening year after year, at the same rate as under TEFRA, would postpone exhaustion until 1989.

CONCLUSION

Any prospective payment system would offer hospitals greater incentives to reduce costs than exist under TEFRA, and the Administration's DRG approach has important advantages over other prospective payment plans. Most importantly, it would not build in inefficiencies that now exist in some hospitals. On the other hand, the specific design of its proposal would lead to a substantial reallocation of Medicare payments among hospitals that would not reflect merely differences in efficiency.

A number of options are available that would address the proposal's shortcomings. For example, adjusting the payment level to take more account of variation in costs between urban and rural areas, or among regions, would reduce the systematic differences in impact by group. The reallocation would also be less traumatic if it went into effect more gradually. One phase-in method, for example, would average a hospital's rembursement under the DRG system with that under the current system of TEFRA limits, with the DRG payment given increasing weight over time. Although administratively more complex, this approach would allow additional refinements in the DRG system on the basis of experience and further research, before a complete transition was made.

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[2] This estimate assumes no futher borrowing by the Old Age and Surviors Insurance trust fund from HI, but no repayment of the $12.4 billion in outstanding loans.

The proposals of the National Commission on Social Security Reform would have only a slight effect on the HI trust fund, an issue that it did not address. Revenues would be increased slightly by requiring all employees of private nonprofit organizations to pay HI tax and by preventing state and local governments from withdrawing from Social Security.

Chairman JACOBS. Thank you very much.

Mr. Moore.

Mr. MOORE. Thank you, Mr. Chairman.

Thank you for your testimony. I am in agreement with the comments you made in your testimony wherein you fear cost shifting if the DRG isn't a fair reimbursement price, or even if it is you have an inefficient hospital and it covers the loss by cost shifting to paying patients.

What solution do you have for that? I read your last paragraph, where you were just talking about a phased-in system. Would that be your solution?

Ms. GORDON. I think you are raising a somewhat broader question that was addressed by the previous witness, Mr. Wyden. His bill would cover all payors and, if you were to take the approach of covering all payors, hospitals would not have flexibility to raise charges for some in order to compensate for lower reimbursements for others.

On the other hand, there would be a greater impact on the health care system than if you restricted any changes to the medicare program itself.

Mr. MOORE. Since we don't have jurisdiction over all payors in this subcommittee, that presents a problem for us. You are referring to a legal way to do it, to have the law say this is all you get and there is nobody else to shift to because everybody is paid under the same system.

Is there any way to construct a competitive model that would not specifically prohibit cost shifting but as a matter of economics, hospitals would not be able to do it since they would price themselves out of business within the community assuming there are two or more hospitals in competition.

Ms. GORDON. I think you could consider other changes that might go into effect at the same time that would influence other people's behavior within the health care system. One possibility would be to limit the amount of employer-paid premiums for health insurance that were tax free. If you were to do that, you would encourage employers and employees to work out fringe benefit packages that had less extensive health insurance. That would tend to make everyone more conscious of costs.

And if everyone was more conscious of costs that might limit the ability of hospitals to shift from one group to another.

Mr. MOORE. That is something I have heard in testimony from Ms. Rivlin before our full committee last year and that is a proposal to come later before our full committee, I assume. I am thinking of some way to construct a model where in a community there were two or more hospitals competing that we could allow charges over the DRG rate up to some limit, providing there was another hospital in the community that would charge less than the DRG rate. In addition, I am looking to find a way of constructing the bonus for the latter hospital so it would be trying to find ways to actually go below the DRG rate as well as allowing those that were talking about going above it to do so at the peril of losing their patients.

Ms. GORDON. In some sense, prospective payment has that feature, because if the hospital can keep its costs down below the amount that medicare reimburses, it automatically gets to keep that difference. That is one of its major advantages. Similarly, if its costs go above, it is stuck with that penalty. I think what you are getting at is how do you prevent the hospitals who are experiencing that penalty from shifting the penalty onto someone else?

Mr. MOORE. Exactly.

Ms. GORDON. It is not clear to me how you do that in a competitive way, since we would have already given the advantage to the hospitals that had lower costs, under the prospective payment approach.

Mr. MOORE. I was also trying to find a way to have the patient be able to participate in the bonus. I want to have a way to have the patient participate so he can seek out the hospitals posting charges less than the DRG.

Ms. GORDON. You could allow the hospital experiencing the penalty to recoup it from the patient. If you took that approach, I think patients would become conscious of the costs of going to one hospital versus another.

You might have some difficulties, however, with patients who couldn't afford to pay if there was no hospital that managed to keep the costs down as far as the DRG limit.

Mr. MOORE. That would be one of the provisos I envision. There would have to be another hospital in the community that charges the DRG or less or the former hospital would not be allowed to go above it. If you would, would you give that some thought for us?

I am very, very concerned about the cost shifting problem. You also pointed out the problem. I am afraid we have that problem right now and those people who have looked at the system are finding that some hospitals that handle a lot of medicare patients are charging such exorbitant rates to other payors.

Ms. GORDON. We would be pleased to work with you and your staff on this issue.

You might also want to consider what are called medi-gap policies, private insurance policies that pick up extra costs not reimbursed by medicare. If you were to follow the route of imposing higher costs on medicare beneficiaries, some of them would continue to have medi-gap policies and that would effectively insulate them from that change. One possible option that was discussed in a recent CBO publication was to tax the premiums for Medi-gap policies, to make the purchaser of them pay more of the total costs that are imposed on medicare when this kind of insulation exists.

Mr. MOORE. Thank you, Ms. Gordon. Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman.

Two or three years ago when we were having hearings on the hospital cost containment legislation, the States that had cost control programs—and I think you alluded to those States—cited evidence that some hospitals were shifting costs from the hospital to the physician, for example, by billing separately for use of the operating room, X-rays and all that. Are you aware of that problem?

Ms. GORDON. I am not sure quite what you mean.

Mr. **Duncan**. Instead of the hospital billing the patient, the physician was billing the patient.

Ms. **Gordon**. You mean for ancillary services within the hospital?

Mr. **Duncan**. Yes, they were shifting them to part B of medicare and they wouldn't show up as hospital costs under part A. Some of these States have actually higher hospital rates than some of the other States that don't have cost control.

Ms. **Gordon**. I am not familiar with this but let me ask Dr. Ginsburg.

Mr. **Ginsburg**. I am sure there is a potential problem in the State programs, and probably in the administration's proposal as well, about possible changes in billing procedures to move some services outside of what is being regulated or controlled.

I cannot give you the details as to the magnitude of the problem and what steps each State is taking to deal with it administratively. We would be glad to look into that further.

[Additional information follows:]

Most of the research on prospective payment has not dealt with this issue. One study of the Maryland rate-setting program did look at its effects on total Medicare spending, including physician payments, but the study had major flaws and is not conclusive.

We know from Maryland rate-setters that they do not address this problem in regulation, but do not consider it serious at this time. Only one hospital in Maryland leases ancillary services to physicians. Rate-setting systems that do not involve review of individual hospital budgets may experience more problems of this nature than Maryland, however.

Mr. **Duncan**. Do you have any suggestions at this time on how we might prevent that?

Mr. **Ginsburg**. I think you could prevent that through detailed rules of accounting. You could require all services performed in the operating room to be billed through the hospital, with no direct physician billing. You would have to establish uniformity one way or the other to make prospective reimbursement work.

Mr. **Duncan**. I have no further questions. Thank you, Mr. Chairman.

I would like to thank both of you.

Chairman **Jacobs**. Counsel for the committee, Ms. Casber.

Ms. **Casber**. Under your analysis a large number of hospitals with bed size of over 300, and teaching hospitals, seem to do poorly under the DRG payment plan. Can you tell us why?

Ms. **Gordon**. When you look at table 1 in the testimony, the first two columns show what happens to all hospitals within different groups. Under the bed size, which is the first breakout, you can see that those that have less than 100 beds are gaining in aggregate 23 percent over the TEFRA reimbursements, whereas those that have 300 beds or more are losing 6 percent in the aggregate.

There are several reasons why you might see this kind of difference. One is that patients in the smaller hospitals may be less seriously ill than those in the larger hospitals. Another is that the differences in costs may not be captured fully by the area wage index that the administration has proposed using. A third reason is that there may be different patterns of practice. Again, those could be related to being in different regions or perhaps to the fact that the patients are actually more severely ill and, therefore, are receiving more tests or more technologically advanced treatment.

Ms. **Casber**. Can you tell me in that same regard, it is commonly believed that publicly-owned hospitals would not do well under a DRG hospital yet your figures seem to not show that, but show the contrary. Why is that?

Ms. **Gordon**. Down at the bottom of this table, you see ownership as Government—that is, the public hospitals—and there is a plus 9-percent aggregate effect. What this really reflects is the difference between public hospitals in urban areas and public hospitals not in urban areas. The urban public hospitals would in fact lose 1 percent as a group, whereas the nonurban public hospitals would gain 26 percent as a group. So it is a combination of minus 1 and plus 26, which comes out to plus 9 for the group as a whole.

Ms. **Casber**. Thank you.

Chairman **Jacobs**. Dr. Gordon, what would happen if the law required termination of contracts between the U.S. Government and hospitals that were involved in cost shifting?

Ms. **Gordon**. Sorry, what would happen if we were to——

Chairman **Jacobs**. If the law said if you shift your costs you cannot do business with Uncle Sam. We won't shop there.

Ms. **Gordon**. If you could show that they had actually shifted their costs, then certainly the medicare program has a tremendous amount of market power. The question would be how would you set it up so that you could be sure that cost shifting had in fact occurred?

Chairman **Jacobs**. If you get a chance we would like the answer to that last question. Any contribution that your office could make we would appreciate.

[The information follows:]

The issue of cost-shifting is a very important one, if Medicare reimbursements are to be restricted. The Congressional Budget Office is currently conducting an analysis for Congressman Rangel that looks at a related question, namely, how hospitals deal with the problem of uncompensated care, including the possibility of shifting costs to other payers. We will be pleased to work with your staff on this as part of the study over the next few months and to send it to you when it is completed. A brief description of the difficulty involved in regulating cost-shifting follows.

Although it might be desirable to restrict the ability of hospitals to shift unreimbursed expenses incurred for treating Medicare patients to other insurers and patients, in practice it would be difficult to implement such a limitation because there is no consensus on what constitutes the legitimate costs of patient care. Hospitals may raise charges to commercial insurers for many reasons, including the recovery of costs not paid by Medicare. For example, Medicare does not provide hospitals with an excess of revenues over expenses—an operating margin. Hospitals argue that they need this operating margin to fund renovation and replacement. Likewise, Medicare does not reimburse costs incurred in providing charity care or costs associated with bad debts. It would be extremely difficult to distinguish future increases in charges to private payers that were due to operating margin and other costs not allowed by Medicare from increases that represented shifting of costs not recognized by Medicare under the DRG proposal.

It would not be necessary to determine the legitimate costs of patient care to implement a proposal to limit cost-shifting, but if this approach were followed, it would be necessary to include all payers to some extent. For example, your suggestion that Medicare deny participation to hospitals that shift costs could be implemented by setting a ceiling on the rate of increase in charges to all payers, with hospitals that exceeded this ceiling being denied participation in the Medicare program. Those facilities with a small proportion of Medicare patients could either limit cost increases or choose not to participate in Medicare. Facilities in which Medicare represents a larger share of the patient load would probably attempt to limit their costs. For those facilities that continued to participate in the Medicare program, this proposal would be equivalent to a reimbursement system involving all payers, because hospital revenues from all payers would be limited.

On the other hand, this proposal would not distinguish hospitals that raised charges to shift disallowed Medicare costs from those that raised charges for other reasons. Also not all cost-shifting would be prevented, because some facilities might be able to raise charges to recoup unpaid Medicare costs without exceeding the ceiling on the rate of increase.

Chairman JACOBS. The theory is you can get a meal at Rive Gauche or at the Hot Shoppes, perhaps it is not well to go to Rive Gauche occasionally, or ever maybe.

Ms. GORDON. That is true.

Mr. GINSBURG. You could work out possible ways of monitoring where there was cost shifting. If you could monitor what the hospital's total revenues were, then you could see if the revenues from the nonmedicare patients increased at a more rapid rate than the costs of serving them. That would be one way of monitoring.

Chairman JACOBS. If I, as a private pay patient, might call into a hospital and see that they charge *x* plus 3 and if *x* is the DRG, wouldn't I have a hint that maybe there is some cost shifting?

Ms. GORDON. That is right. Certainly, if their patients knew the charges that were based on DRG's that would be one way.

Mr. DUNCAN. Mr. Chairman, if I may, when we were on this problem before I think one thing that perhaps ended it was that they didn't want to pass on food costs and on costs of labor. Do you have a suggestion? They were the biggest costs in the hospital—labor and the breadbasket, as we called it back then.

Ms. GORDON. The basic costs of care, room and board and basic nursing?

Mr. DUNCAN. What would you suggest on how we handle those costs? That was the big item then and that is what ended the debate. No one wanted to freeze labor and we couldn't freeze the cost of the food.

Ms. GORDON. Basically the hospital has to purchase its input in the market, and so I think any given hospital would have limited ability to affect the wages it was paying or the price of whatever inputs it was buying. But the administration's proposal would start with a certain base amount and would vary that by the amount that the wages varied in different geographic areas, on the theory that the hospital cannot control that.

Mr. DUNCAN. Thank you.

Chairman JACOBS. The administration's current proposal is not strictly a pass-through, is it? It's on a regional basis, much as the blue-collar worker is compensated by the Government now?

Ms. GORDON. That is right. That is absolutely correct. If the hospital was able to lower its costs by paying less, it would keep the difference.

Chairman JACOBS. The committee expresses its gratitude to you and your colleagues, Dr. Gordon.

Ms. GORDON. We are pleased to have been here. Please let us know if we can help you in any other way.

Chairman JACOBS. I already let you know we would like a response to that question I had. We have given you a hint.

The next panel is the American Hospital Association, Jack Owens, executive vice president; Federation of American Hospitals, Keith Weikel, president-elect; and Association of American Medical Colleges, Richard Knapp, director, Department of Teaching Hospitals.

I am happy to say that the 5-minute limit is on.

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. **Owen**. Thank you, Mr. Chairman.

I am Jack Owen, executive vice president of the American Hospital Association. We represent about 6,000 hospitals across this country of various ownership, size, and type.

You have my written testimony, so I won't spend any time at all on that. I would just like to comment on what we think are several important issues that need to be looked at in this particular proposal.

In answer to some of the discussion that took place a few minutes ago, I would like to again reiterate our concern about the patient participation in this program. You heard Dr. Gordon say that the hospital insurance trust fund will be out of money in 1987 or 1988 even with the squeeze down. We think that the patients are participating at the present time through deductibles and copay, and we can avoid some of the cost shift that Mr. Moore talked about and some better selectivity on the part of patients if there is a method by which the patient participates. We would like to see that that continues.

If there is just assignment and nonassignment, you reach a point where the costs are well below the fixed costs of an institution. The real problem is will that institution continue to participate in medicare? And if we don't, are we taking away something from the patients in a community where they need to have the hospital there?

We would urge that as you look at this problem that the questions that you gave Dr. Gordon you follow up on; and if we can be of any help, we would be happy to do that.

I would like to comment on the problem of the national rate versus the hospital-specific rate. We have proposed that we use a hospital-specific rate because of the concerns that we have in starting out a program of this magnitude knowing that the national rates are fairly gross and that over a period of time there will be some hospitals that will be much harder hit than those that will have windfalls, so to speak.

I think in the summary Dr. Gordon pointed out some of those problems. I think there is room for negotiations, whether we start out over a period of 2 or 3 years as a phase in with hospital-specific working toward a national rate or if we work out a system where at least 50 percent of the hospital-specific rate is used and perhaps part of it is a national rate.

We did this in New Jersey when I was there, and it worked fairly well. It seems to me that jumping right into a national rate can create some problems for a good many of our hospitals, and we hope that the committee will look hard at that and see if there isn't a way to phase it in or come up with a more realistic answer than just a national rate.

I would like to also express my concern for some of the smaller hospitals who are members. Some of these hospitals don't have the data processing or the ability to move into a system this fast. It is a complicated system, and we think that there ought to be some phase in for those hospitals who are less than 100 beds who have a problem and need some time in order to get into the system.

I think that overall the statistics we just heard from CBO show that small hospitals will do fairly well. But we know that in some areas, where they are 50 beds or less, that one or two long lengths of stay will throw the system out of kilter because it is based on averages. And when you average, you need a large number in order to make it meaningful.

We have two other concerns that I would like to bring up. One has to do with the appeals mechanism, which is not in the Secretary's bill. We feel that there should be a method for hospitals to appeal at least certain parts of this program whether it is the DRG mechanism makeup—what happens if their hospital does not agree with the intermediary, whoever is setting and looking at the hospital from the standpoint is that DRG proper or not? And we think there should be administrative appeal.

We also think there should be appeal for future rates that are set which brings me to my last point: Future rates of this program. At the present time in the administration's bill the Secretary has sole discretion for future rates. We think that this is not quite proper, that it either ought to be spelled out in legislation such as the market basket plus one or better. We prefer there be a panel of economists who might take a look at what the ongoing rate should be.

Thank you very much.

Chairman JACOBS. Thank you, Mr. Owen.

[The prepared statement follows:]

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Jack W. Owen, Executive Vice President of the American Hospital Association. AHA is the principal national organization of hospitals, with some 6,300 member institutions and more than 35,000 personal members. I am pleased to have this opportunity to testify on proposals for prospective payment for Medicare, and I commend you for your expeditious attention to this issue.

In my statement, I will first review the background which has led AHA to its support of prospective payment, then outline several principles which must underlay any prospective payment system for Medicare, and finally comment on the major conceptual elements of the system which the Department of Health and Human Services (HHS) described in its report to Congress in December.

BACKGROUND

AHA strongly supports the adoption of a prospective payment system for most hospital services under Medicare. Our support is the result of more than two years of careful study of the effects on hospitals of steadily worsening payment shortfalls under traditional retrospective cost-based reimbursement. In 1981, a working party of our Council on Finance concluded that the only viable, lasting payment strategy for the hospital field is to develop new, innovative prospective pricing approaches which balance financial risks and rewards, such that hospitals are adequately paid for efficient and effective management and are penalized for poor performance.

Accordingly, during last year's hearings on the Fiscal Year 1983 budget, we called for an end to short-range, narrowly focused tinkering with the Medicare reimbursement system, and committed AHA to work with Congress on long-range structural reform of the incentives which confront hospitals, other providers of health care, and consumers. We followed through on that commitment by proposing an interim prospective payment system, based on average per-discharge payments. Our proposal was designed to implement the first stages of a full prospective payment system, while addressing the clear consensus in Congress for short-term federal savings.

While Congress did not enact our proposal, it did incorporate some elements of prospective payment in the Tax Equity and Fiscal Responsibility Act (TEFRA), P.L. 97-248. The target rate provides, for the first time in Medicare, a limited recognition of the principle that hospitals which incur costs below a prospectively-determined amount can retain savings, rewarding performance in a manner similar to that used in the rest of the economy.

It is important to recognize that the Medicare hospital payment provisions in TEFRA were primarily intended as an expedient to meet short-range budget goals. Rather than lessening the need for Congress to act on a succeeding system, they greatly increase the importance of legislative action in 1983. If Congress allows true payment reform to languish until 1984 or later, then hospitals and other providers will be faced with having to accommodate the full three years of limits, which could cause significant financial dislocations for many hospitals, affecting the availability of care to many Medicare beneficiaries.

The expansion of the Section 223 limits to total costs per case, and the ratcheting down of these limits in fiscal years 1984 and 1985, will eclipse the beneficial incentives of the target rates for most hospitals. The Section 223 methodology, under which hospitals are grouped according to superficial similarities, provides no assurance that penalized hospitals are inefficient. A given hospital's Section 223 limit is determined less by its own cost behavior than by the behavior of other hospitals in its group, over which it has no control. Therefore, while the target rate is a step forward, it will be canceled out by the Section 223 limits.

PRINCIPLES FOR PROSPECTIVE PAYMENT

This past autumn, after TEFRA had been enacted, AHA undertook an extensive review of its original proposal and the underlying principles for prospective payment. The working group which had drafted the proposal was reconvened and expanded to consider refinements. Its recommendations were considered at a series of regional meetings of hospital leaders across the country and by the regular policymaking bodies of the Association.

A set of fundamental principles developed from these deliberations, which in our view must form the basis for a prospective payment system for Medicare hospital services. These principles include:

(1) The system should balance the needs of government, providers, and beneficiaries, and establish consistent financial incentives for all parties to moderate the growth in Medicare spending over the long term.

(2) The system should not be an instrument for arbitrary, short-term budget reductions.

(3) A prospective payment system alone cannot overcome the negative impact on beneficiaries or providers of inadequate financing, or of counteracting demand incentives, under Medicare.

(4) The system should provide a reasonable degree of financial predictability for the government, beneficiaries, and providers, so that the financial consequences of health care decisions can be known in advance.

(5) The system should balance the financial risks for all parties.

(6) The system must be sensitive to the case-mix of each hospital, so that hospitals are paid for the services actually provided.

(7) The system should provide equitable payments, so that hospitals are not penalized for providing services to beneficiaries and so that well-managed hospitals can accumulate capital for modernization and appropriate expansion.

(8) The system should provide incentives and adequate payment to hospitals for maintaining beneficiaries' choice and access to high quality services.

AHA has revised its original proposal, and a description is attached. Let me emphasize that while AHA's recommendations may differ from the Administration's or other proposals, those differences are meant to be constructive contributions to Congress' development of a sound, workable system, and should not be viewed as impediments to action. We are prepared to move forward now, working with your committee and other committees in Congress and the Administration, to develop a mutually acceptable system. We believe this can be accomplished in this session.

THE HHS PROPOSAL

Although AHA has some concerns about the HHS proposal, we commend the Department, particularly Secretary Schweiker, for their commitment to adopting prospective payment in Medicare. This initiative, if it is carried out, will be a major contribution to strengthening the program in the years to come and to providing a catalyst for positive change in the entire health care system. We trust that Secretary-designate Heckler will pursue this proposal with equal vigor and that the Administration will make this a priority for 1983.

Keeping in mind the principles outlined above, let me turn to the HHS proposal. What we know at this point is derived from the December report to Congress. Since knowledge of many of the details must await specific legislation, I will confine my comments today to the conceptual elements described in the report, and will follow up later with reaction to the legislative provisions.

Scope of covered services

The HHS proposal would apply to acute inpatient services, presumably leaving other hospital services under the current system.

We recommended that prospective payment be applied to all hospital services. Different units of payment, such as per diem or negotiated rates, could be used where per case is not appropriate. If nonacute services, such as rehabilitation and psychiatry, were left under the target rate and Section 223 limits, or other controls, then new calculations would have to be made, somehow comparing nonacute costs among hospitals, no doubt producing anomalous results. Moreover, the cost reporting and auditing burdens of the current system would, in large measure, remain, cancelling out a major administrative cost benefit of prospective payment.

Startup date and transition

The HHS proposal would begin as early as October 1, 1983. We believe this is a feasible date to begin a phased transition to the new system; however, the HHS report does not indicate how such a transition would occur.

The experience in New Jersey with Diagnosis Related Groups (DGRs) should be instructive. Two types of problems were faced in implementing their experimental system. First, hospitals and governments needed to be protected from sudden changes in revenue and outlay. Second, some hospitals did not have the data collection and processing capability on hand to adapt to the new system.

This experience suggests that hospitals without adequate data capability (e.g., some small hospitals and publicy-owned institutions) should have time to acquire the management systems needed before having to join the new system.

Data needs

Hospitals' experience in New Jersey with DGRs, and nationally with the target rate and Section 223 limits, demonstrate the critical importance of intergrating accurate patient care data with current financial data—a linkage which has not been required in Medicare in the past.

HHS proposes to use the MEDPAR data base and three-year-old cost reports to established the DRG payment rates. We recognize that currently this is the only practical approach, but we have serious concerns over the accuracy of the MEDPAR data on a hospital-by-hospital basis, and over the validity of using old financial data updated by an arbitrary inflation index.

We recommend that current data bases be used to set initial rates, and that HHS undertake an intensive effort to upgrade its data collection and processing capability, so that DGR rates can be adjusted in future years to reflect accurate patient care and financial information in each hospital. As a first step, HHS should make available to hospitals the MEDPAR data base, so that its accuracy can be verified. Congress should mandate that all data used in calculating prospective payment rate be avilable to hospitals without delay.

Payment unit

AHA supports the use of DRGs as the unit of payment, however, we recommend that the DGR rates be calculated on the hospital's own cost base, not on a national average as HHS has proposed.

The use of DGRs is consistent with an important principle for any prospective payment system: that it be sensitive to the case-mix in each hospital, so that payments are made with an accurate reflection on the resources used in providing Medicare services.

Adjustments to payment amounts

The HHS proposal provides that the Secretary may adjust the payment amounts periodically to reflect inflation and new technology costs. While we certainly agree that such adjustments must be made, we believe they they should be done on a regularly scheduled basis, with the formula specified in law and calculated by a technical body that is independent of HHS and capable of providing an objective adjustment.

Similarly, the proposal would permit the Secretary to adjust DRG weights to reflect changes in medical patterns of practice and resources used in providing services. Again, we certainly agree that such updating is necessary, but we recommend that a fixed schedule be established, for example every three to five years for each DRG, with the re-evaluation done by an independent technical panel.

The HHS proposal also would "pass through" capital and direct teaching costs. We agree that costs must be fully recognized in each hospital's payments, and that pass-throughs are a practical method of recognizing these costs in the initial years of prospective payment. Ultimately, we hope that payment amounts would be equitable, permitting capital costs to be subsumed within the total price itself. The fundamental point is, however, that teaching hospitals must be able to finance their teaching programs and that all hospitals must be able to accumulate capital for replacement, modernization, and expansion to meet growth and change in demand for services.

Exceptions and appeals

The HHS proposal would permit only one basis for exceptions—designation of a hospital as a sole community provider. Moreover, it would preclude judicial review of payments.

We believe that exceptions must be allowed on other grounds, such as circumstances beyond a hospital's control, so that individual institutions may obtain appropriate adjustment in their payments. Decisions on exceptions should be made by a panel that is independent of HHS, to insure objectivity. Both HHS and hospitals should have access to federal courts to adjudicate disputes over the system and obtain relief. These mechanisms constitute an important check and balance.

Waivers

The HHS proposal apparently would not permit waivers for alternative systems. We believe that waivers not only should be permitted, but also that they should be encouraged. Waivered systems provide the source of experimentation and innovation which can strengthen the program. A given national payment system should not be taken as perfect. New ideas should be encouraged and tested, so that the program can evolve and adapt.

Assignment/nonassignment

The HHS proposal would require hospitals to accept the payment amount as payment in full, and would prohibit hospitals from charging beneficiaries amounts beyond the copayments and deductibles.

We believe that hospitals must be given an option of "nonassignment," that is, to be able to charge beneficiaries amounts beyond the Medicare payment. This option is necessary to permit some hospitals from incurring financial losses resulting from their participation in Medicare.

While we understand that this is a difficult concept for many to accept, Congress must begin to recognize that Medicare is changing inexorably from an open-ended program to one with financial limits. Also, other payers are now vigorously resisting the shifting of Medicare payment shortfalls, removing the traditional method for absorbing financial losses due to Medicare payment limits. These trends make it inevitable that Medicare beneficiaries must accept more of the payment burdens for services that are more costly than the government is willing to finance.

Many hospitals will choose to accept assignment. Community attitudes toward assignment would heavily influence hospital administrators' and trustees' decisions, as would beneficiaries' subsequent use of nonassignment hospitals. In this regard, nonassignment is an important stimulus to competition; nonassignment institutions would have to compete with assignment hospitals for Medicare patients, and beneficiaries could choose between institutions on the basis of assignment as well as service mix and amenities. Beneficiary incentive must be consistent with the incentives for hospitals, if the federal government is to moderate the growth in Medicare spending.

SUMMARY

Mr. Chairman, we believe that Congress should enact a prospective payment system for Medicare hospital services. The first step was taken last year in the target rate provision of TEFRA, but the Section 223 limits will eclipse those positive incentives unless Congress acts this year.

Certain basic principles should form the foundation for prospective payment, so that consistent incentives apply to government, hospitals, and beneficiaries for long-range progress toward more cost-efficient behavior.

American Hospital Association

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Proposed American Hospital Association Position on Medicare Prospective Pricing

Approved By the Board of Turstees and
Referred to the House of Delegates
February 1, 1983
Approved By the House of Delegates, 2/2/83

Presented below is the American Hospital Association's (AHA) proposed design for a Medicare prospective pricing system for hospital services based in general hospitals. The proposal does not address future Medicare payment to free-standing, specialty hospitals, as the AHA is awaiting further advice on this subject from these segments of the membership. This proposal is presented as a next step in the evolution of the Medicare program's approach to paying for hospital services. It can be implemented as early as October of 1983.

This proposal recognizes and is built upon several fundamental philosophical principles and operating realities:

- The long term solution to the Medicare program's financing and cost problems will require changes in the incentives that influence decisions by patients, hospitals and other providers. The adoption of a prospective payment system which changes hospital incentives is part of the answer, but an effective, comprehensive solution requires the simultaneous pursuit of other actions to affect the demand for as well as the supply of health care services.

- Over a decade of experience with alternative payment mechanisms has demonstrated that effective prospective payment systems must be responsive to local conditions. The knowledge and experience derived from these programs support the conclusion that a national Medicare prospective payment system should be viewed as an evolutionary step. Accordingly, this proposal incorporates strong waiver opportunities for local initiatives.

- The proposed prospective pricing system is preferable to the current payment mechanism. It increases financial predictability and decreases administrative burdens for both hospitals and the federal government by substantially reducing cost reporting and auditing requirements. More importantly, it provides the managerial flexibility, incentives and financial capacity necessary for hospitals to be able to continue to meet the needs of Medicare beneficiaries.

- Regardless of the Medicare payment system and related controls being utilized, the federal government, by its payment method and amount, controls the qualitative dimensions and advancement of health care services which it is willing to finance. Beneficiaries should have the opportunity to pay additional amounts if they deisre health care services exceeding the federal government's definition of adequate care. To provide this opportunity, hospitals must have the option of charging amounts beyond the federal government's price. To do otherwise would not only limit beneficiary freedom of choice, but jeopardize the financial viability of hospitals for other users.

Scope of Services

All services based in general hospitals will be covered, including general acute medical and surgical inpatient services, outpatient services, and services provided in distinct inpatient psychiatric, skilled nursing, or rehabilitation units of hospitals.

Effective Date and Expiration

Payment on the basis of prospective prices will begin with hospital fiscal years beginning on or after 10/1/83; it will end with hospital fiscal years beginning on or after 10/1/87.

Hospitals Covered

All general hospitals, regardless of size or location, will participate in the system. Small, rural hospitals, however, may obtain special adjustments for problems caused by significant changes in either volume or mix of admissions. In addition, hospitals under 100 beds and located in non-SMSA's will have the option of being paid under this system or remaining in the current retrospective system for a period of three years (without Section 223 limits).

Beneficiary Liability

Currently required deductibles and copayments will be continued.

On an annual basis, a hospital will elect for each major category of service (e.g., inpatient acute, outpatient and emergency room, distinct psychiatric, skilled nursing or rehabilitation units of hospitals), to accept the Medicare payment as payment in full (assignment) or to bill individual beneficiaries amounts in excess of the fixed price paid directly to the hospital by Medicare (non-assignment). If a hospital elects to bill, it may do so for the amount by which its regular charges for services to a particular beneficiary exceed Medicare's payment to the hospital for that same beneficiary.

Basis of Payment

Hospitals will be paid for acute inpatient services according to a schedule of diagnostic-specific prices. These prices will be set on the basis of diagnosis related groups (DRGs). In the initial year, a hospital's price schedule will be set using: 1) the hospital's actual Medicare cost-per-case in the prior year; 2) an annual rate of increase factor; and 3) a system of national cost weights reflecting the costliness of treating a patient in each DRG relative to the average cost of treating the "typical" Medicare patient. In subsequent years, the price base to which the annual rate of increase factor is applied will be the prior year's DRG-specific prospective prices.

- The annual rate of increase factor will be a composite of a technology factor and a hospital market basket rate of increase forecast. The construction of the market basket index will be legislatively specified and the forecasts will be computed by an entity external to the federal government. The market basket index and forecasts will be regional to the extent permitted by the data. The DRG-prices will be adjusted for significant forecasting errors.
- Capital costs will be treated as a pass through.
- Medical education costs will be treated as a pass through.
- Decisions on hospital requests for exceptions to the established prices will be made by an independent panel, with only the federal
- courts having the authority to review and change the panel's decisions. Hospitals may request exceptions for:
- errors in computations or in the data applied by the administering body;
- arbitrary and capricious actions by the administering body;
- changes in the severity of illness within the hospital's beneficiary case mix;
- unusual labor or non-labor market inflation not adequately reflected in the market basket component of the price index;
- special needs and financial hardship of sole community providers;
- disagreements with the administering body over the appropriate initial year's price base for newly constructed hospitals, new hospital inpatient rehabilitation and psychiatric units, and new hospital skilled nursing units (see below); and
- unforeseen and unusual circumstances, including but not limited to matters currently under litigation.

New words underlined

Services provided in distinct inpatient psychiatric or rehabilitation units of hospitals will be paid for on the basis of either a per diem prospective price or a DRG-specific prospective price, at the hospital's option.

Hospitals will be paid for services provided in distinct part skilled nursing units of hospitals on the basis of a per diem prospective price.

Hospital-based outpatient, emergency, and home health services will be paid on the basis of regional, usual, customary, and reasonable (UCR) charges. The reasonable charge level will be a specified percentile of base period charges of only hospitals* providing the specific type of service or procedure in the region, increased by an appropriate economic index.

Assignment/Non-Assignment

Hospitals accepting the Medicare fixed price as payment in full for acute inpatient services will:

- continue to be reimbursed by the Medicare program for beneficiary bad debts related to regular deductibles and copayments;
- receive an automatic increment in computing their fixed price as a return on equity factor, (in the case of investor-owned hospitals) or as a capital maintenance factor (in the case of not-for-profit hospitals);
- receive an automatic increment in computing their price if they serve high portions of Medicare and low income inpatients.

Hospitals not accepting the Medicare fixed price as payment in full will be required to:

- notify beneficiaries in advance that they might be billed for services and the extent of the potential obligation which might be incurred;
- file with their intermediary their charge schedules and annually disclose to the public their beneficiary charging practices.

Utilization Control

The federal government will be responsible for ensuring the medical necessity and appropriateness of beneficiary admisions.

Any hospital with an effective internal admission control program will be granted "deemed status," exempting it from externally conducted utilization review.

For hospitals not granted deemed status, payment for services will be denied where beneficiary admissions are determined to have been medically unnecessary or inappropriate. In such instances where Part A payment is denied, the related Part B payment will also be denied.

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* This approach takes into account historical distortions in hospitals' costs and charges for these services caused by Medicare's cost allocation and charging requirements.

Waivers

The federal government should provide for an aggressive Medicare prospective pricing waivers program, under which a group of hospitals, or a state that has the approval of the affected hospitals, can establish and operate an alternative Medicare payment system. This waivers program will not be subject to a sunset provision, and (renewable) waivers will be granted for a minimum of three years. Decisions on waiver requests will be made on a timely basis by a new national commission, staffed by the Secretary of HHS and with balanced representation of business, labor, government and hospital industry leaders. The commission will approve waiver requests if (a) reasonable assurances have been provided that the applicant's proposal will result in total Medicare payments during the waiver period no greater than those anticipated under the federal Medicare prospective pricing system; or (b) the proposal offers a significant opportunity to advance the state of knowledge concerning hospital prospectrive pricing.

Other Features

The initial year's acute inpatient price base for newly constructed hospitals, which have been in operation for less than three years prior to the commencement of the prospective pricing system, will be negotiated with the intermediary, taking into account the prospective prices of hospitals of similar size providing similar services in similar input price markets. The initial year's price base for hospitals with new (in operation less than three years) skilled nursing units, as well as for hospitals with new distinct part inpatient rehabilitation or psychiatric units opting for per diem prospective prices, will be established in the same manner.

Prospective prices for hospital inpatient services should be adjusted automatically to account for changes in the hospital's capital costs and capital structure resulting from a bona fide change in ownership as determined through the application of Internal Revenue Service rules.

STATEMENT OF RICHARD KNAPP, DIRECTOR, DEPARTMENT OF TEACHING HOSPITALS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. **Knapp**. I am Dick Knapp, and I am here this morning representing the Nation's teaching hospitals.

The association's written testimony will discuss our concerns with the HHS proposal and offer a series of constructive recommendations for its improvement. Rather than discuss those technical items, I would like to briefly discuss four basic matters. In doing so, it needs to be kept in mind that the administration proposal is expenditure-neutral. Therefore, what we are talking about is a redistribution of dollars. That is our concern.

Can the proposal accomplish this purpose in a fair and equitable manner? We believe the answer is no, and that there are serious problems that need your attention. First, crucial details are lacking. Despite its 220 pages the Department's "Prospective Payment Report" is not complete. Many crucial details necessary to evaluate the proposal are not described, including the pass-through computations, payment for out-liers or atypical cases, indirect medical education costs, et cetera.

Therefore, the report lacks the information necessary for an individual hospital or group of hospitals to estimate fully the revenue impacts of the proposed system.

Second, statistical averages mask appropriate individual differences. The association is concerned with the repeated references to the statements that on average the statistical formulas are reasonable and the repeated references to the statisticians law of large numbers which allegedly provides protection against adverse hospital impacts.

Of the almost 6,000 community hospitals in our Nation, only 6 percent are major teaching hospitals. While HCFA may feel relieved that perhaps most hospitals are treated reasonably by the proposal, teaching hospitals are concerned that they constitute the bulk of the minority adversely impacted.

As discussed in our written statement, several characteristics of the Secretary's report suggest teaching hospitals may be the most adversely affected because of their special characteristics and contributions.

The CBO numbers presented this morning confirmed our concerns and suspicions. You should be aware that since 85 percent of our members are over 300 beds we do have a large concern.

Teaching hospitals do more and cost more. Teaching hospitals do have higher average costs than nonteaching hospitals. Without attempting to define or defend every dollar of the difference this morning, we do believe teaching hospitals' higher costs are justified. These additional costs allow additional products to be produced, medical, nursing, and allied health students are trained, medical science to be advanced and refined, new and more effective technologies are introduced into medical care, better modalities of care are developed, and complex patient services are provided.

Four, the proposal threatens hospital/physician relationships. The goal of the HHS proposal is to set a reasonable hospital price for a reasonable hospital product. Yet looking at the proposal's incentives it becomes clear that the prospective payment proposal addresses hospital services but focuses heavily on physicians and their impact on relationships with hospitals.

As an association of hospitals and physicians, the AAMC is in a unique position to comment on a payment system which seeks to alter physician behavioral patterns by changing hospital payments. The relationships between hospitals and their medical staffs are often delicate and highly individualized having been developed at the most local level. The HHS proposal will disrupt these relationships through an abrupt change in hospital payments.

The AAMC believes that more evolutionary change is preferable to the HHS proposal. Therefore, the association strongly recommends moving to a prospective payment system but one that determines payment on a per-discharge basis by type of case using an individual hospital's actual cost per case adjusted for inflation as determined from the medicare cost report period immediately prior to the implementation of the prospective payment.

Thank you for your attention, and I will try to answer any questions you may have.

Chairman JACOBS. Thank you, Mr. Knapp.

[The prepared statement follows:]

STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to testify on the Medicare proposal submitted to Congress by Secretary Richard S. Schweiker which advocates prospectively determined hospital payments for Medicare patients. In addition to representing all of the nation's medical schools and 73 academic societies, the Association's Council of Teaching Hospitals (COTH) represents 329 state, municipal, and not-for-profit hospitals. These hospitals account for 18 percent of the Medicare admissions to non-federal short-stay hospitals. Because Medicare patients often have more serious illnesses than younger patients, frequently require above average nursing and personal care services, and generally stay longer than other patients, Medicare patients account for over 28 percent of total hospital revenue in COTH hospitals. As a result, dramatic changes in Medicare payments policies for hospital services are a vital concern of the Association and its members.

The members of the Association are aware of the significant concerns about the continued financial viability of the Medicare program that have induced Congress and the Administration to consider changes in the way in which hospitals are paid for the care of Medicare patients. However, in considering proposals for making these changes, Congress should evaluate the ability of the proposed systems to provide the necessary cost savings while: Fairly recognizing the differences in services necessarily provided to patients with different types and severities of illness; not discriminating against an identifiable group of providers or sector of the hospital industry; providing incentives for both short- and long-term cost-effective behavior; appreciating that differences in cost not accounted for by the formula ultimately chosen are not necessarily related to inefficiency but reflect real and important differences between hospitals; allowing grievance and redress procedures to counteract regulations which may have serious damaging consequences to patient care and hospitals; and fairly providing for implementation of the system.

This last point is particularly important when considering the changes contained in the HHS proposal. The method of implementation should reflect an understanding of the limitations of the data used in developing the system, provide for the time needed by the hospitals to alter their management behavior, and make provision for continued improvement of the proposed payment system.

As you will note from our comments, the AAMC believes that the HHS proposal is deficient in addressing these points. Moreover, despite the 220 page length of the Secretary's report on prospective payment, the Association wishes to note that weaknesses in the report prevent a fully informed analysis. First, many of the necessary crucial details of the proposal are not developed in the proposal. For example, no information is included: On the procedure which will be used to trend forward data from the time of its collection to the time of its use in payments, on the specific procedure to be used to determine capital and direct medical education cost "pass throughs," on the methodology to be used for computing the proposed "lump sum payment" for the indirect costs associated with intensity of medical education activity, or on the specific procedure to be used to pay hospitals for the atypically costly cases called "outliers."

Secondly, the report lacks the information necessary for an individual hospital to estimate fully the revenue impacts of the proposed system. Thirdly, the report fails to include an impact statement describing the financial consequences of the proposal on different types of hospitals. Because the HHS proposal is essentially a modification of the present Section 223 methodology, it can be assumed, at a minimum, from data in the September 30th Federal Register that the HHS proposal will most heavily impact hospitals in New England, the Great Lakes and upper midwest, and the west. It will also impact relatively large numbers of small urban and rural hospitals. Without additional HHS data, other disproportional impacts cannot be determined. The Association assumes these shortcomings will be ultimately addressed in a subsequent legislative proposal and requests an opportunity to appear once again before this Subcommittee when more detailed information is available.

AAMC POSITION

The proposal, as submitted, includes five design characteristics which are desirable, in principle, for prospective payment systems based on nationwide data comparisons:

1. The use of a "per case" unit of analysis and payment emphasizes that the decision to admit a patient is the primary determinant of utilization, minimizes incentives to increase units of service, and promotes examination of present diagnosis and treatment regimens.
2. The explicit recognition of patient case mix in determining payment recognizes, within the limits of the present methodology available, that hospitals are not homogenous and allows year-to-year changes in the mix of patients to be immediately reflected in the amount of payment.
3. The inclusion of an area wage adjustment partially compensates hospitals for geographic differences in these costs.
4. The "pass through" of direct medical education costs and the lump-sum payment for indirect medical education costs provide some recognition of the added costs teaching hospitals incur in operating graduate medical education programs.
5. The "pass through" for capital costs recognizes that physical plant and major equipment expenses are primarily historical costs reflecting prior year decisions, prior interest rates, and former construction and supply costs.

In spite of these design characteristics and the Association's general advocacy of prospective payment, the AAMC does not believe that the methodologies and data advocated in the Secretary's report can be used without substantial risk to the financial stability of hospitals. Moreover, the report assumes that hospitals can add and omit services largely as a result of the economic incentives included in the payment system. This assumption fails to recognize that hospitals must meet their community roles and responsibilities for service, even when a necessary service is economically unattractive. Therefore, the AAMC strongly recommends that an initial, national propsective payment system: Determine payments on a per discharge basis by type of case using an individual hospital's actual costs per case as determined from the Medicare cost report period completed immediately prior to the implementation of prospective payment.

A hospital-based, per type of case prospective payment system based on a hospital's own base year costs provides the best next evolutionary step in hospital payment. Such a system provides hospitals with an incentive to become more cost conscious; it provides physicians with an incentive to carefully evaluate present practice patterns. A hospital-based, per case prospective payment system provides these incentives without the inevitable detrimental consequences of the Secretary's proposal.

EVALUATION OF HHS PROPOSAL

In the balance of this testimony, the HHS prospective payment proposal is evaluated in light of nine prospective payment principles advocated by the AAMC. Criticisms of and concerns with the proposal are raised and recommendations are made, where possible, for changes and modifications.

Principle 1.—Prospective payment systems should fully recognize the impact on operating costs of the hospital's approved scope of services, its patient mix, and the intensity of care required.

AAMC concerns

1. The HHS proposal makes no attempt to recognize differences in hospital operating costs arising from differences in hospital size and scope of service.
2. The newly formulated, 1981 diagnosis related groups (DRG's) do not explicitly recognize differences in illness severity within a diagnostic grouping. Thus, they do not recognize differences in the intensity of services which must be provided to patients within the same DRG.
3. HHS is unable to use properly the DRG's to classify patients because: The 1982 DRG's were constructed under the assumption that all diagnoses and procedures must be considered to assess the patient's use of hospital resources, but HCFA has data only on the principal diagnosis and procedure, and on the presence or absence of secondary diagnoses and procedures. Thus a complete description of the patient's medical condition is not available or used in classification.
4. The proposal's use of average costs and cost-to-charge ratios for estimating the cost of an individual patient's care understates the cost of tertiary care and overstates the cost of routine care.
5. The proposal's procedure for classifying cases understates the cost of patients with complicating conditions while overstating the cost of patients with no complications.
6. The methodology HHS proposes to establish per case prices, excludes ancillary services not billed through the hospital. Because different hospitals have had different arrangement for ancillary services, some hospitals may be more favorably treated by the rates than others.
7. The 1981 patient data which HCFA proposes using to set 1984 payments rates: Include substantial errors because hospitals had no incentive to provide accurate and complete diagnostic and procedural data, rely on inconsistent intermediary practices for reporting and verifying diagnostic and procedural classifications, and fail to reflect changes in medical practice between 1981 and 1984.
8. The present proposal contains no information on how the atypically costly cases, called outliers, will be reimbursed. This is a vital issue for referral centers having, which relatively large volumes of atypically costly patients, would be seriously harmed by use of national averages.

AAMC recommendations

1. In previously computing Medicare cost limits, HHS has grouped hospitals based on bed size and hospital location to provide greater assurance that similar hospitals are being compared and that real differences in hospital costs are not being ignored. Under its prospective payment proposal, HHS should continue to group hospitals in this way.
2. Consideration should be given to excluding from the per case payment overhead expenses which are unrelated to direct patient care such as utilities, plant maintenance, and security.
3. In order to insure that any national average cost per case and the cost weights are properly calculated, HHS should verify that there is consistent reporting of data between institutions, and make adjustments where necessary.
4. HCFA should immediately review the new uniform billing form approved last year to assure it will provide more complete and more comprehensive diagnostic and procedural information.
5. HHS should consider excluding from the prospective payment proposal special-care hospitals (e.g., cancer hospitals) that may attract more acutely ill patients than the average community hospital within each of the DRG's they treat.
6. In constructing the per case payment rates, HHS will amass substantial information on resource use patterns implicitly underlying per case rate. Publication of the following per case information would assist hospitals in evaluating present practice patterns and in preparing appeals: The average length of stay in special care unit beds for each DRG, the average length of stay in routine care unit beds for each DRG, the average proportion of each DRG rate resulting from ancillary services, the average proportion of each DRG rate resulting from laboratory services, the average proportion of each DRG rate resulting from X-ray services, and the charge, cost, or length-of-stay values used to exclude some patients as atypically expensive, i.e., outliers.

Principle 2.—Prospective payment systems should recognize regional differences in the costs of goods and services purchased by hospitals.

AAMC concerns

1. The HHS proposal assumes uniform wage rates throughout an urban or rural area, while past HCFA research shows labor costs are higher in central-city than in suburban areas.

2. The HHS proposal uses a wage index adjustment which assumes each W-2 wage report is for a full-time employee. This assumption and the resulting index unfairly penalize those geographic areas having atypical numbers of part-time workers, atypically high turnover, or relatively heavy use of registry nurses by understating the hospital's true cost of labor.

AAMC recommendations

1. HCFA should immediately enter into a joint project with the Bureau of Labor Statistics to develop wage indices separating labor costs in the core cities of Standard Metropolitan Statistical Areas from those in surrounding suburbs.

2. HCFA should work with the Bureau of Labor Statistics to prepare wage indices based either on average hourly compensation rates or full-time-equivalent personnel.

Principle 3.—Propsective payment systems should calculate operating costs on a "going concern" basis with full recognition of hospital capital requirements.

AAMC concerns

1. While the payment proposal asserts that historical data used to set prices will be updated to reflect inflation, no constraints are imposed on the Secretary for defining allowable hospital inflation rates.

2. The HHS methodology assumes all Medicare patients fully pay deductibles and coinsurance. When Medicare patients fail to pay these required charges, the hospital should be able to claim reimbursement retrospectively for these amounts from the Medicare program.

AAMC recommendations

1. An advisory board to the Secretary should be established to provide an impartial estimate of the increase in hospital input prices, assist the Secretary in evaluating alternatives during implementation, and study and report on any adverse consequences resulting from the new payment system.

2. Under the proposal, a hospital could receive substantially less revenue in the first prospective payment period for the same number and mix of patients admitted in the last retrospective payment year. The inclusion of a "grandfather clause" precluding total prospective payment revenue less than final year retrospective payment would lessen the threat of undermining the hospital's fiscal viability in the initial years.

3. Because a formula-based prospective payment system is dramatically different from past cost reimbursement, it may result in substantial windfalls and shortfalls for individual hospitals. A three-year implementation period which sets each hospital's payment per case as a blend of its own costs and the payment rate (e.g., 75 percent own/25 percent standard; 50 percent own/50 percent standard; 25 percent own/75 percent standard; 100 percent standard) would moderate early year excesses and short-falls.

Principle 4.—Prospective payment systems should recognize physician costs for personal medical services and for medical program supervision and administration.

AAMC concern

1. In some hospitals, significant hospital costs are incurred for salaried professional and technical staff paid on a fee-for-service basis in other hospitals. If costs in all hospitals are averaged to compute national case weights and average per discharge prices, hospitals will receive "windfalls" or penalties depending upon hospital/staff payment arrangements.

AAMC recommendations

1. Hospital costs for physicians' providing medical care to individual patients should not be included in the prospective rate.

2. Physician compensation for medical program supervision and unit administration should be paid on a cost reimbursement basis rather than as part of the prospective rate.

Principle 5.—Prospective payment systems should recognize costs resulting from manpower training programs which are accredited by an apporpriate organization. Costs recognized should include those for educational instruction and supervision, student stipends where provided, program support and institutional overhead, and the decreased productivity accompanying training in the hospital setting.

AAMC concerns

1. The HHS proposal contains no information on how the lump-sum payment for the indirect costs of medical education will be computed.

2. While nursing education costs have been removed from Section 223 limits, these costs are not removed from the prospective payment rate. Thus, hospitals with costs for nursing education programs are penalized for participating in the programs.

AAMC recommendations

1. The adjustment for the indirect costs associated with medical education should be computed as a percentage increase in the otherwise determined per case payment. As in the present Section 223 limits, the size of the percentage increase should be directly related to the number of residents per bed.

2. As in Section 223 limits, costs of nursing education should be treated in the same manner as those for medical education.

Principle 6.—Prospective payment plans should recognize the patient care costs associated with clinical research to bring advances in biomedical knowledge to the improvement of medical care.

AAMC concerns

1. While grants and contracts for research projects generally provide the primary funding for the clinical research activity itself, grants and contracts generally do not pay for the patient care costs that would otherwise be incurred as a result of the patient's illness. The patient treated under an approved research protocol remains in the original DRG category despite his more intensive patient care requirements. Because research programs result in concentrating these patients in a limited number of hospitals, the distribution of high cost patients is constrained. Hospitals with large clinical research programs and unusually ill patients will be penalized by a payment system based on the average case.

2. The use of national averages per type of case rather than payment based on specific experiences of the individual hospital removes resources for innovation from those institutions which have demonstrated the motivation and capability to improve care, and distributes those resources to the hospitals which have not done so. This is contrary to the Secretary's stated intention to provide incentives for innovation (p. 35 of report).

AAMC recommendation

1. The AAMC would be pleased to work with Subcommittee members and their staffs to develop an adjustment for the atypical intensity of care required for patients participating in approved research protocols.

Principle 7.—Prospective payment systems should recognize increased costs accompanying the use of new diagnostic and treatment technologies.

AAMC concern

1. Unlike the present Section 223 and percentage increase limits, the HHS proposal includes no specific recognition of the costs of the new diagnostic and treatment technologies. While the report does say that payment can be modified to reflect "... new technology proven to be cost effective ..." (p. 64), no mechanism is provided in the proposal to demonstrate the desirability of new technologies. The increasing importance of CT scanners demonstrates an excellent example of the way in which one can seriously misjudge the benefits of new technologies when focusing upon their costs.

AAMC recommendation

1. The AAMC would be pleased to work with Subcommittee members and their staffs to develop an adjustment for hospital costs accompanying the introduction of new technologies and modalities of care.

Principle 8.—Prospective payment systems should permit hospitals to charge patients for the differences between the program's payment and the posted charges for services used.

AAMC concern

1. The HHS proposal prohibits billing the patient for more than the mandatory deductibles and copayments. As proposed, participation in the Medicare program is

a one-sided contract. The Government would specify both the benefits that must be provided and the total price for them. Because most hospitals are general medical/surgical facilities caring for patients of all ages, it is virtually impossible for hospitals to withdraw from the Medicare program. As a result, the one-sided contract envisioned in the HHS proposal is coercive and permits both arbitrary and capricious pricing by the government.

AAMC recommendation

1. To assure patients access to a hospital of their choice and to minimize shifting costs of Medicare patients to other payers, hospitals should be permitted to charge patients for the difference between the Medicare payment (including deductibles and copayments) and the posted charges for services received. Hospitals electing to bill patients should be required to inform patients of this billing policy prior to the patient's admission.

Principle 9.—Prospective payment systems should provide hospitals with a statutory right to obtain administrative and judicial review of program policies and payment computations.

AAMC concerns

1. The HHS proposal includes no mention of any administrative appeals mechanism for addressing erroneous data or computations, atypical patient severity, or underutilized but necessary specialty services.
2. The HHS proposal specifically precludes judicial review of any aspect of the payment system.

AAMC recommendations

1. At a minimum, hospitals with substantially atypical situations (e.g., seasonal fluctuations, catastrophic events) should be able to obtain administrative exceptions to the payment rates.
2. Because all formula-based approaches are limited by underlying assumptions, errors in input data, and weaknesses in the methodology, hospitals should be able to request administrative relief from an independent review board with functions similar to the GSA Board of Contract Appeals.
3. Because the proposal includes broad discretionary authority to the Secretary and imposes essentially a coerced contract on hospitals, hospitals should be able to obtain judicial review of agency decisions and actions.

CONCLUSION

While the AAMC recommends that the payment limits enacted in the Tax Equity and Fiscal Responsibility Act of 1982 be replaced with a prospective payment system for hospitals, the defects and weaknesses in the HHS proposal are serious, raise substantial questions of equity, and assume hospitals have essentially homogeneous products. Rather than amending the HHS proposal to correct or limit its defects, this Committee is urged to develop a per discharge payment system based on a hospital's historical operating costs per case type with adjustments for changes in patient case mix and input prices.

Chairman **Jacobs**. Mr. Weikel?

STATEMENT OF M. KEITH WEIKEL, PRESIDENT-ELECT, FEDERATION OF AMERICAN HOSPITALS

Mr. **Weikel**. Thank you, Mr. Chairman. I am president-elect of the Federation of American Hospitals. Last year we believe Congress took a very important step toward developing a reimbursement system for more efficient delivery of health care. Although this system is still based on a retrospective cost reimbursement, we believe it represents an important step toward more sound policy in medicare reimbursement.

One major problem with this current provision, however, is that the target rate of increase is calculated on each hospital's base costs. This penalizes low-cost hospitals because their allowable dollar increase is smaller than facilities with higher base costs.

The most important provision in the bill, we believe, directs the Secretary of HHS to develop and report to the Congress by the end of 1982 a prospective payment plan for medicare reimbursement to hospitals. That report has been submitted and we believe it outlines a promising legislative proposal for changing the incentives of the medicare payment system.

The federation has long supported a prospective payment system and the elimination of retrospective cost reimbursement. We think it imperative that Congress act quickly to implement such a system so that we do not once again have to face the annual charade of tinkering with the present reimbursement system, making arbitrary cuts in the medicare program by redefining reasonable costs, and without achieving necessary fundamental reform of the program.

A new system acceptable to Government should certainly include budget savings and predictability, administrative simplicity, incentives for efficient delivery of services, and the ability to implement the new system quickly and consistently with the competition principles supported by the administration.

Hospitals essentially desire many of the same principles. Hospitals will certainly want assurances that the new system would be equitable, will allow hospitals the opportunity to recover their full financial requirements, and involve less regulation. Other third-party payers will look at the system to see whether it minimizes cost shifting. Beneficiaries will certainly be concerned about the scope and equity of any cost sharing elements as well as freedom of choice of providers.

In our written testimony we have listed on page 3 a payment plan designed to recover their financial needs, although it would not guarantee recovery if their prices are too high. They would assure beneficiaries of catastrophic protection which they do not have under current medicare law. They would minimize the need to cost shift by redesigning the time of copayment. They would save dollars and provide budget predictability to Government. Finally, they are consistent with the competition strategy of the administration stressing consumer choice and incentives for restraint in utilization.

The administration has recommended a medicare prospective payment system based on a competitive price per diagnosis. That type of medicare system, while clearly a cost control device, is preferable to the existing system of cost reimbursement with ceilings because it offers incentives and rewards. We consider it conceptually as a positive reform.

We also recognize that this type of cost control device, while imposed on hospitals, is really intended to change the behavior and practice patterns of medical staffs. The whole point of replacing cost reimbursement with a fixed rate per case is to provide an incentive to restrain spending. Some of that spending involves management decisions but a larger part involves utilization of services and procedures which are ordered by physicians. This concerns us but we believe the alternative continuation of cost reimbursement with ceilings is worse.

There has been considerable concern that inadequacies in medicare and medicaid reimbursement have resulted in some hospitals raising their charges to payers who pay for care on a charge basis. There is similar concern that if medicare should proceed to pay hospitals on a prospective DRG basis, this cost shifting would continue and perhaps be increased.

It should be understood that if the incentives in a plan are in the direction of lowering hospital costs generally, all payers, not just medicare, would benefit from the lower costs. In any case we believe if DRG-based prospective rates are appropriate for medicare, it does not seem reasonable to fail to adopt them purely on cost shifting requirements. It seems more appropriate for each party to determine its own payment rates for services.

Our association supports the general direction of the medicare prospective payment system proposed by the Department of Health and Human Services. Notwithstanding a number of our concerns about the validity of the data base, adjustments to base prospective payment schedules, the treatment of new technologies, and the need for an equitable appeal mechanism, we urge the committee to approve the Department's plan with the 10 modifications which we have listed in our test beginning on page 6. I would just like to touch on a few of these.

The Department should publish the proposed fiscal year 1984 DRG pricelist so they can be reviewed by Congress and the hospital industry priority to their adoption. We think that is very critical.

Second, hospitals should be held harmless to each institution's prior year's actual average cost per admission for the first 2 years of the prospective payment system to assure an orderly transition to a more accurate data base.

Congress should incorporate a basic formula for updating payment rates in the statute to prevent arbitrarily low forecasts of inflation or failure to recognize effective technological improvements.

Finally, hospitals must have the right to judicial as well as administrative review of decisions which determine the rates of payment, as well as an exception procedure for unique circumstances in which patient care could be adversely affected.

These are just some of the changes which we believe need to be taken into consideration in your deliberations, Mr. Chairman. However, we do believe that prospective payment is clearly something that needs to be acted on promptly.

Chairman JACOBS. Thank you.

[The prepared statement follows:]

STATEMENT OF M. KEITH WEIKEL, PH. D., PRESIDENT-ELECT, FEDERATION OF AMERICAN HOSPITALS

SUMMARY OF TESTIMONY

Our association supports the general direction of the Medicare prospective payment system proposed by the Department of Health and Human Services. We urge the Committee to approve the Department's plan with the following modifications designed to improve the system:

Recommendation One.—The charge data file and DRG cost weights used to determine the Medicare prospective price schedule per diagnosis should be updated in the future—at least once every five years—to utilize more accurate base-year data when available.

Recommendation Two.—Hospitals should be held harmless to each institution's prior year's actual average cost per admission for the first two years of the prospective payment system to assure an orderly transition to a more accurate data base.

Recommendation Three.—Annual price adjustments should be implemented for all DRGs according to a Congressionally mandated formula with additional adjustments for specific DRGs determined by the Secretary with outside expert advice to reflect technological advances.

Recommendation Four.—Hospitals must have the right to judicial as well as administrative review of decisions which determine the rates of payment, as well as an exception procedure for unique circumstances in which patient care could be adversely affected.

Recommendation Five.—New institutions should be exempt from the system for three years and provision should be made for recognizing certain major operating cost increases associated with new capital.

Recommendation Six.—Educational and capital needs should be separately reimbursed on a cost basis during the initial years of any prospective payment plan. Capital costs must include depreciation, interest, and return on equity for investors as historically reimbursed by the program.

Recommendation Seven.—Hospitals should have the right to bill patients for the difference between Medicare payment rates and charges applicable to private patients for similar services not to exceed a reasonable catastrophic ceiling per case.

Recommendation Eight.—Congress should direct the Department to reduce paperwork and eliminate all cost reporting not absolutely necessary for determining capital, educational, or other costs not covered by the prospective price schedules.

Recommendation Nine.—The Department should continue to study the need for adjustments to the price per diagnosis schedules and the feasibility of adjustment for factors such as severity of illness and regional differences in the market basket for purposes of annual price changes.

Recommendation Ten.—The Department should also study and recommend prospective payment plans for those specialty hospitals, such as psychiatric, children's, and rehabilitation facilities and outpatient hospital services, which do not easily fit in a DRG-type system.

Mr. Chairman and Members of the Subcommittee, my name is M. Keith Weikel, Ph.D., President-Elect of the Federation of American Hospitals and Group Vice President of American Medical International, Inc.

The Federation of American Hospitals is the national association of investor-owned hospitals and hospital management companies, representing 1,045 hospitals with over 120,000 beds in the U.S. alone. Our member hospital management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all non-governmental hospitals. In many communities, investor-owned facilities represent the only hospital serving the population.

Congress recently cut the Medicare program by $2.9 billion for fiscal year 1983, hospitals incurring $700 million of those 1983 cuts. While Congress made some changes in Medicare reimbursement to hospitals by expanding Section 223 limits to cover all costs on a per-discharge basis and redefined reasonable costs by eliminating the nursing differential and the private room subsidy, we still have a cost-based retrospective payment system which historically has fueled health care expenditure increases and fails to provide incentives for efficiency and reduced utilization.

However, Congress did take an important step towards developing a reimbursement system for Medicare which the Federation has long supported which offers economic incentives for more efficient delivery of health care. The tax equity bill allows incentive payments for those hospitals with Medicare costs below an established target. Hospitals below their target rate would, for the first time, be allowed to retain half of the difference between their actual Medicare costs and their target rate, thus providing a financial incentive for hospitals to lower costs by rewarding them for doing so. Although still based on a retrospective cost reimbursement system, this represents an important step towards more sound policy in Medicare reimbursement. One major problem with this current provision, however, is that the target rate of increase is calculated on each hospital's base costs. This penalizes low cost hospitals because their allowable dollar increase is smaller than facilities with higher base costs.

The most important provision in the bill, we believe, directs the Secretary of HHS to develop and report to the Congress by the end of 1982 a prospective payment plan for Medicare reimbursement to hospitals. That report has been submitted and we believe it outlines a promising legislative proposal for changing the incentives of the Medicare payment system.

The Federation has long supported a prospective payment system and the elimination of retrospective cost reimbursement. We think it imperative that Congress act quickly to implement such a system so that we do not once again have to face the annual charade of tinkering with the present reimbursement system, making arbitrary cuts in the Medicare program by redefining "reasonable costs," and without achieving necessary fundamental reform of the program.

A new system acceptable to government should certainly include budget savings and predictability, administrative simplicity, incentives for efficient delivery of services, and the ability to implement the new system quickly and consistently with the competition principles supported by the Administration.

Hospitals essentially desire many of the same priniciples. Hospitals will certainly want assurances that the new system would be equitable, will allow hospitals the opportunity to recover their full financial requirements and involve less regulation. Other third-party payers will look at the system to see whether it minimizes cost shifting. Beneficiaries will certainly be concerned about the scope and equity of any cost sharing elements as well as freedom of choice of providers.

We believe the concerns of all parties involved can be satisfied by adhering to the following guidelines:

The payment system should pay a fair price sufficient to allow efficiently and economically operated hospitals to provide quality services at a fair return on investment from the government and beneficiaries.

The payment system should be fair and equitable and should include an exception/appeal process to include judicial review. It should recognize the full economic requirements of hospitals, the geographic differences in these economic requirements and the special circumstances of individual hospitals.

The payment system should be basic in design, administratively simple and economical to operate and should avoid complex formulae.

The payment system should be based on objectively determined prospective rates to be adjusted at least annually in order to encourage optimum planning and the predictability of expenditures and income.

The payment system should encourage through economic incentives, including consumer cost sharing, the efficient utilization of services by beneficiaries and physicians.

The payment system should allow hospitals the ability to bill patients for the difference between a fair price and Medicare's payment to reduce cost shifting. The payment system should contain appropriate provisions for beneficiary catastrophic coverage.

The payment system should allow reasonable time for the development and implementation of a base year, appropriate roll-forward provisions, and a conversion period from the present to the prospective payment system with appropriate input by hospitals.

These principles would assure hospitals of the opportunity to recover their financial needs (although it would not guarantee recovery if their prices are too high). They would assure beneficiaries of catastrophic protection which they do not have under current Medicare law. They would minimize the need to cost shift by redesigning the time of copayment. They would save dollars and provide budget predictability to government. Finally, they are consistent with the competition strategy of the Administration stressing consumer choice and incentives for restraint in utilization.

The Administration has recommended a Medicare prospective payment system based on a competitive price per diagnosis. That type of Medicare system, while clearly a cost control device, is preferable to the existing system of cost reimbursement with ceilings because it offers incentives and rewards. We consider it conceptually as a positive reform.

We also recognize that this type of cost control device, while imposed on hospitals, is really intended to change the behavior and practice patterns of medical staffs. The whole point of replacing cost reimbursement with a fixed rate per case is to provide an incentive to restrain spending. Some of that spending involves management decisions but a larger part involves utilization of services and procedures which are ordered by physicians. This concerns us but we believe the alternative—continuation of cost reimbursement with ceilings—is worse.

There has been considerable concern that inadequacies in Medicare and Medicaid reimbursement have resulted in some hospitals raising their charges to payers who pay for care on a charge basis. There is similar concern that if Medicare should proceed to pay hospitals on a prospective DRG basis, this cost shifting would continue and perhaps be increased. It should be understood that if the incentives in a plan are in the direction of lowering hospital costs generally, all payers not just Medicare would benefit from the lower costs. In any case, we believe if DRG-based prospective rates are appropriate for Medicare, it does not seem reasonable to fail to adopt them purely on cost shifting requirements. It seems more appropriate for each party to determine its own payment rates for services.

Our association supports the general direction of the Medicare prospective payment system proposed by the Department of Health and Human Services. Notwithstanding a number of our concerns about the validity of the data base, adjustments to base prospective payment schedules, the treatment of new technologies, and the need for an equitable appeal mechanism, we urge the Committee to approve the Department's plan with the modifications to improve the system:

Hospitals should be held harmless to each institution's prior year's actual average cost per admission for the first two years of the prospective payment system to assure an orderly transition to a more accurate data base.

Congress should incorporate a basic formula for updating payment rates in the statute to prevent arbitrarily low forecasts of inflation or failure to recognize effective technological improvements.

Finally, hospitals must have the right to judicial as well as administrative review of decisions which determine the rates of payment, as well as an exception procedure for unique circumstances in which patient care could be adversely affected.

Chairman JACOBS. Mr. Moore?

Mr. MOORE. Thank you, Mr. Chairman.

Mr. Owen and Dr. Weikel, both of you have commented on something that is of concern to me. That is the business about the assignment versus nonassignment.

I am wondering if there is a way, you tell me if it would work, within your member hospitals, to construct a situation that where there was two or more hospitals in the same community, of allowing one to charge above the DRG if the other would accept the DRG rate or charge less. I am thinking of a cap of some kind on the amount of the excess charge or politically it will not pass through the Congress. I have suggested 10 percent. In order further competition between the hospitals the patient could choose between them and if he chose the less costly one he would pay less of the medicare deductible. According to the schedule I have seen it works out where both the medicare program and the patient would benefit. And assuming the hospital would be able to increase its productivity and efficiency it could make money at less than the DRG rate. A hospital that wasn't efficient and could not provide the service at that level and had to charge more, would be allowed to do so providing the patient wished to pay, and the amount was not more than 10 percent above the DRG rate.

What would you think about something like that?

Mr. OWEN. Let me start off. I think the possibility exists. You have to remember also that the DRG system will have a rate for each kind of diagnosis, so that the hospital may lose some money on two or three diagnoses and may make money on others. That would lend itself to the competitive model that you are talking about, in which a hospital perhaps could say that they could offer an appendectomy at no charge to the patient where another hospital would not.

I think that could be worked out. I don't think it is that difficult. I think the problem is where you require that there be another hospital in the community, because in many communities in this country there are not two hospitals. And I think that would be more difficult to require that. I think we would have to take a look at that and see whether that would be possible.

If there is a cap, I think whatever one is concerned about is the aged person is going to be left where he loses his home and all of his assets because of the huge hospital bill. And with a catastrophic cap on we could alleviate that fear.

I think the other point is that medicare is not a program for the poor. It is a program for the aged, and there are an awful lot of aged people who are not poor and who could pay Medi-Gap insurance and pay their own bills, in which they selected hospitals with a higher cost, even on the basis they would select a higher hotel or restaurant, as the chairman suggested, they will do that.

I think they ought to have that right. I think that possibly does exist. But if you try to say no patient is going to pay, in some instances where here is a hospital and those DRG rates are less than their fixed costs, then I suspect that hospital will have to make a very hard decision whether they participate at all in Medicare.

Mr. MOORE. You and I are looking at the problem a little differently. You are looking at the practical problem of running a hospital. I am looking at a practical political problem of passing a prospective plan. I have been warned already that if we have an open-ended system, as the hospitals would like to have, where they charge anything above the DRG rate that they have to have that is not going to fly politically. The Members of the Senate and the House are not going to vote for a system like that, even though, as you point out, there are many medicare recipients who could well pay above that rate.

So I am trying to find within the political and economic constraints a system under which we can allow hospitals to charge more in situations where the service is available in the community in a hospital that will accept DRG rates or even less. If the patient goes to the less costly hospital he would pay less of the medicare deductible. That is what I am trying to construct. Otherwise I think we are going to stay with the system as is being proposed by the administration. I just don't think we will pass one with an open-ended charge.

Mr. WEIKEL. We firmly believe there should be a cap, a catastrophic cap.

Mr. MOORE. That comes much later.

Mr. WEIKEL. And it should not be open-ended. In terms of your specific proposal, how would it impact the industry? I think that if some—a hospital in the community were allowed to charge more than the DRG, and the patient could pay the difference if they chose to take services at that hospital versus another, that that would clearly begin to place a market price value on that—whether patients believe they are getting enough additional services in that institution to pay the additional charge. So you would begin to move toward a more realistic market type.

Mr. MOORE. That is what I am looking for, competition in the marketplace. We assume we have a community with more than one hospital. The one I come from has seven or eight hospitals. I know that many communities have just one. In that case it is going to be the DRG rate, I am afraid. However, in communities with two or more hospitals we could go DRG by DRG—take the appendectomy case. One hospital says we cannot do it for that rate, so it will be DRG plus. The patient has the choice of going there or to the less costly hospital across town, and we likewise allow them to charge below the DRG rate, and charge less deductible to the patient. This would create competition between the hospitals as well as benefit the patient financially.

What I am asking all three of you gentlemen is do you think something like that, within those constraints, would be workable in terms of creating a competitive situation?

Mr. KNAPP. There are some of those DRG's that have very tight distributions. There are other DRG's where there is a very wide distribution of cases within them. And I think that if we were to go in that direction, for that group where there is a wide variation, you cannot really make the assumption that those patients are similar enough so that a price comparison is a fair one. I think you need to look at that part of the equation as well.

Mr. MOORE. We have that as a given. I am trying to take the givens and trying to make it more competitive.

Mr. OWEN. The AHA, last year, before TEFRA, suggested there be a $2,500 limit that a hospital could charge. We never backed away from that. But we are not pushing it right now. There has been thoughts along that line, if there would be a limit.

Mr. WEIKEL. I think it would get you toward a competitive system, assuming you have more than one hospital in a community.

Mr. MOORE. All of this becomes easier if we pass the administration's catastrophic plan. But that is a big "if." Right now I am not hearing the assured support of that among my colleagues.

Thank you for your candor and your testimony.

Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Duncan?

Mr. DUNCAN. Thank you, Mr. Chairman. I want to thank the panel.

Any one of you can answer this. Do you know what percentage of patients have the Medi-Gap insurance, medicare patients?

Mr. OWEN. I really don't know.

Mr. DUNCAN. Could you get that information?

Mr. KNAPP. Yes.

Mr. DUNCAN. I understood from the staff it is about 60 percent.

What about malpractice insurance. Is that a big item in the hospitals?

Mr. OWEN. I can comment, maybe, because I was in a malpractice company in New Jersey before I left there. It is a problem, there is no question about that.

But the malpractice rates have not gone up in New Jersey under the DRG system. That has not made a difference in the malpractice rates. In fact, they have gone down since 1976. So I don't think that is necessarily a reason why malpractice rates would go up.

They will go up for other reasons, like court awards and other things like that. But DRG did not seem to make a difference from any other system we had.

Mr. DUNCAN. Is it a large cost per bed in a hospital?

Mr. OWEN. It is substantial. But——

Mr. DUNCAN. What would it run normally?

Mr. OWEN. $1.50, $2, in New Jersey.

Mr. WEIKEL. Basically I think our experience is the same. A number of the firms in our federation are self-insured for malpractice. They have their own captive insurance companies. And that has also made a difference in lowering some of the costs of malpractice insurance.

Mr. **Duncan**. Is it $2, $1.50?

Mr. **Weikel**. Slightly under that.

Mr. **Duncan**. Thank you very much. Thank you, Mr. Chairman.

Chairman **Jacobs**. Ms. Casber?

Ms. **Casber**. Mr. Knapp, you raise a number of problems that teaching hospitals have with prospective payment. Yet I had the feeling you did support the concept in general. Mr. Owen suggested a phase-in. Would a phased-in program go a long way to resolving the problems of teaching hospitals?

Mr. **Knapp**. There are a couple of kinds of phase-ins. One a blended rate; one a question of whether you want to use all the DRG's. Those phase-in matters, coupled with bed size, a clear understanding of how the out-liers are to be paid, and what the definition of an out-lier is, and a better understanding of and at least some assurance on our part of how indirect medical education costs are paid would help.

Our problem is like everybody else's. We don't particularly like this proposal. We don't like TEFRA. So that leaves us somewhat in that middle range. I think that is a fair assessment of our position.

Chairman **Jacobs**. The Chair thanks the panel for its contribution.

The next panel consists of the National Association of Counties, John H. Stroger, Jr., chairman, health and education steering committee and commissioner, Cook County, Ill.; Volunteer Trustees of Not-for-Profit Hospitals, John L. Sinn, chairman of the board and president of the board, Eisenhower Medical Center, Rancho Mirage, Calif.

STATEMENT OF JOHN H. STROGER, JR., CHAIRMAN, HEALTH AND EDUCATION STEERING COMMITTEE, NATIONAL ASSOCIATION OF COUNTIES, AND COMMISSIONER, COOK COUNTY, ILL., ACCOMPANIED BY MATTHEW COFFEY, EXECUTIVE DIRECTOR, NACO

Mr. **Stroger**. Mr. Chairman and members of the subcommittee, I am pleased to be here today, on behalf of the National Association of Counties [NACo]. I serve as chairman of the National Association of Counties Health and Education Steering Committee. With me today is Matthew Coffey, executive director of NACo.

We appreciate your giving us the opportunity to testify early in this session on the legislation because it presents both opportunities and concerns that need our joint efforts. For many years the National Association of Counties has supported an equitable, effective reimbursement system for medicare and medicaid.

As providers, financers, planners, and purchasers of health care services, counties in one way or another have a role in addressing the health care needs of virtually all Americans. Of the 1,900 public hospitals in this country, 800 are county facilities. As any of the members of the subcommittee who have served in county government know, county hospitals are the hospitals of last resort for the indigent or elderly.

If you saw the Wall Street Journal of February 10, as relates to the Alabama situation, what is happening there and throughout the country, you will understand what we are talking about.

Nationwide, local tax revenues support the provision of county health services for many of the over 26 million Americans who have no health insurance, and the additional millions who have inadequate coverage. I think you will agree that the issue of health care and cost containment and the potential impact of perspective payments under medicare is of critical concern to us. A recently released American Hospital Association/Urban Institute study shows that the 15 largest public hospitals, including Cook County, Mr. Chairman, provided a total of $597 million in nonmedicaid charity care in 1980 alone.

ADMINISTRATION APPROACH

The National Association of Counties supports this administration's attempt to bring skyrocketing hospital costs under control, and we support the concept of prospective reimbursement in providing incentives to the health care profession to contain costs.

Prospective payments are recognized by the association as valuable because rates would be set at the beginning of the fiscal year, and hospitals, aware of their patient case mix, would be able to plan their budgets with more information. They would also have the added incentive to operate as efficiently as possible because they would keep any savings they achieve. By the way, this does not apply to county hospitals and public general hospitals. On the other hand, they would have to absorb losses incurred by spending more than the set rate on cases.

COUNTY HOSPITAL ROLE

We are concerned that any prospective approach must contain provisions that recognize county hospitals as the only true safety net in our health care system. We recognize the need for exemption from diagnostic-related group limits for public hospitals with caseloads representing a higher percentage of poor and indigent patients. My county, Cook County, has determined, after preliminary analysis, that the 1980 data, which the diagnostic groups are based on, does not reflect the actual costs. This is particularly true as it pertains to the multiple and severe illnesses experienced by our poor and indigent patients.

In a second study released last month the Urban Institute speaks of the unique financial burden for public hospitals as providers of last resort. They have determined that public hospitals in the 100 largest localities devoted about 40 percent of their patient care service to care for the poor. They point out correctly that the hospital problem of financial stress overlaps with the social problem of financing health care for the poor.

One other concern we have is our concern about how well the diagnostic system will address the severity of illnesses, as well as multiple, complex diagnoses, so often seen in the indigent patients we serve. If the diagnostic related group system cannot adequately reimburse for such complex diagnoses, local governments will continue to be called upon to fill the gaps. This will compound the financial burden on counties, forcing us to increase the proportion of the scarce property tax dollars allocated to health care.

RECOMMENDATIONS

As we continue to develop our recommendations in this area we would like to work with your committee, Mr. Chairman, to develop appropriate amendment language to address the problems. We have received assurances from the Office of Management and Budget that they would be more than willing to work with us in developing amendments to their proposal in recognition of these problems.

Mr. Chairman, the association feels that any new payment system should include budget savings, predictability, administrative simplicity, and incentives for efficient delivery of services.

Implementation of this new system must be at a pace which would recognize the constraints health care providers will be under as they adjust to a dramatically new way of doing business.

Finally, we understand that there is some consideration of attaching the medicare prospective payment proposal to the legislative package on social security reform. If that proposal is under serious consideration, we would appreciate the opportunity to discuss it with you and your staff at a later time. Our present policy supports both programs separately.

Mr. Chairman and members of the subcommittee, these are our major concerns. We do, however, have additional recommendations and observations listed in our testimony. We ask that our testimony in its entirety be enclosed in the record and that the association staff working with your staff address each of these concerns. At this point, Mr. Chairman, I would be happy to answer any questions about the three points that we have mentioned above.

I have staff here who professionally can address themselves, if I am not prepared. And if it is something we could get and bring back to you later, we are prepared to do so.

Mr. Chairman and members of the committee, I would like to leave with you the executive budget recommendations for Cook County health programs—retained in subcommittee files—that we have been working on in our county right now, so that your committee would have this and see what we are expending in terms of caring for the poor of our county.

Chairman. JACOBS. Thank you, sir.

[The prepared statement follows:]

STATEMENT OF JOHN H. STROGER, JR., COMMISSIONER, COOK COUNTY, ILL., ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES

ADDITIONAL RECOMMENDATIONS AND OBSERVATIONS

The development of a mechanism that allows counties an opportunity to participate, on an annual basis, in reviewing with the Health Care Financing Administration, the effects of the prospective payment system, regarding any cost shifting that may be taking place. This would aid the Federal Government, as well as the providers in setting the next year's rates.

The Administration proposal apparently would not permit waivers for alternative systems of reimbursement. We believe that waivers not only should be permitted, but that they should be encouraged because a given national system should not be taken as perfect.

Waivered systems provide the source of experimentation and innovation which can strengthen the program. Alternative systems could also aid in recognizing regional differences in the costs of goods and services purchased by hospitals.

The proposal should contain language requiring private hospitals to at least maintain their present charity patient load; ensuring that no hospital reduce its share of care to "unprofitable" patients, recognizing that private hospitals and physicians might unload their uninsured or under-insured patients on the public hospitals.

In this same vein, if hospitals charge beneficiaries what is not covered under diagnostic related groups, and if private insurers resist paying the extra costs for the beneficiary, counties will, once again, be forced to pay the remainder of the bill. The cost shifting implications may be even more severe as patients who are not covered in these circumstances apply for other forms of public assistance.

Educational and capital needs should be separately reimbursed on a cost basis during the initial years of any prospective plan. Many of the county public hospitals are also teaching facilities. We concur with the position taken by the Association of American Medical Colleges that any prospective payment system should recognize costs resulting from: Manpower training programs; educational instruction and supervision; and, patient care costs associated with clinical research.

The Health and Human Services medicare diagnostic related group proposal calls for a fixed rate. A fixed rate precludes adjustments for serious misprojections. As we all know projections of the costs of severe illnesses are at best guesses. Congress should incorporate a basic formula for updating the payment rates in the statute to prevent arbitrarily low forecasts. As providers of services we would appreciate the opportunity to comment in the process of adjusting rates.

We are encouraged by the administration's stated willingness to vary rates based on wages. Considering our extremely varied membership of both urban and rural counties this is a very important provision.

At present, the administration's proposal is not subject to judicial review. Hospitals and local government should not be denied judicial as well as administrative review if they wish to contest aspects of the approved rates.

No automatic exception is granted to small rural hospitals. Because of the new reporting requirements and needed access to computer services these hospitals should be allowed lead time to adjust to the new plan.

We appreciate the opportunity to make th[illegible] comments and recommendations and look forward to working with the committ[illegible] developing the legislation and any subsequent amendments.

Chairman **Jacobs**. Mr. Sinn?

STATEMENT OF LINDA MILLER, A[illegible] ON BEHALF OF JOHN L. SINN, CHAIRMAN OF THE [illegible] UNTEER TRUSTEES OF NOT-FOR-PROFIT HOSPITA[illegible]

Ms. **Miller**. I am Linda Mill[illegible] Mr. Sinn was unable to get into Washington. I am here on his behalf, representing the Volunteer Trustees of Not-for-Profit Hospitals, and speaking in the interests of all the Nation's voluntary hospitals—the 5,000 not-for-profit hospitals who for the last half century have provided the proving ground for American medicine, the miracle of American medicine.

I emphasize this because it is in jeopardy. The voluntary hospital sector is the wellspring of training, teaching, research, and technology; and of community care: for the poor, the underprivileged and the underinsured. It is meals on wheels, it is 24-hour emergency care, it is obstetrics when it is not profitable, and it is medicare and medicaid, sometimes 70 percent of a hospital's total patient load.

Prospective payment—the proposal before us from HHS—is yet another procedural device for reimbursement. If it means equity of payment under medicare it is good; if it does not, it is not good. Prospective payment in and of itself is less important a decision than the rules under which it is administered.

Cost-based reimbursement has been a mistake from its inception: wrong incentives, mistaken projections, and understanding of the Nation's potential for medical progress. But of that we are all agreed. The question before us is how to change and how to create a system of fairness that achieves our social goals.

I believe that there is no one in this room—or on this committee—who would postulate that one of those goals is to halt the revolution in medical technology and care. And yet this proposal, as sent to OMB and now before you, deliberately jeopardizes the future of the voluntary hospitals by specifically denying only to them a return on equity.

Any operating institution—whether operated for the purpose of making a profit for stockholders or operated solely as a community service—requires a positive operating margin to continue its mission. It is essential for the purchase and replacement of equipment, for expanding care, for renovation and for evolving technological trials.

The medicare program currently assists for-profit hospitals in making that needed surplus by providing them with an additional payment over and above their costs, which is called a return on equity; that is, a payment based on the amount of net stockholder equity capital devoted to the enterprise. However, no similar payment is provided to nonprofit hospitals under medicare for the amount of equity they have built up and invested in their enterprises.

For medicare to have twisted this basic financial reality for so many years has been unfair. But for the Congress now to go out of its way to create an exception and deliberately perpetuate this inequity would be ruinous. What possible sense does it make to include a return on equity in order to assure payments to stockholders, and to deny it to not-for-profit hospitals where the benefits go only to the community and to services for the community. This should not be interpreted as a plea to deny return on equity to for-profit hospitals; far from it, they require it. But so do not-for-profit hospitals.

Prospective payment is touted as a first and fair step to competition. But, in a price-competitive setting, a proprietary hospital receiving a bonus payment from medicare merely because it is proprietary will have an ever growing advantage over its nonprofit competitor. Proprietary hospitals will compete with a governmentally assisted advantage.

This advantage is entirely contrary to the competitive spirit of prospective payment for another reason, too. The return on equity paid by medicare to investor-owned hospitals is paid without any regard whatsoever for the efficiency of the hospital. All investor-owned hospitals are paid a return on equity at the same fixed rate whether they are admirably efficient or grossly inefficient. Nothing could be more abhorrent to a competitive system than to give a governmentally granted advantage to an inefficient hospital simply because it is operated for the purpose of making a profit.

It is sometimes argued that other governmental activities—particularly the tax laws—balance out this return on equity advantage that medicare gives to proprietary hospitals over nonprofits. That is simply untrue. To the extent that tax laws give concessions to nonprofit hospitals, it is because they operate as public charities for the sole purpose of serving their communities and absorb the burden of teaching and research and care for the indigent that proprietary hospitals do not carry as a part of their mission.

Under the guise of a system that treats all hospitals equally, this proposal would actually pay more money to a hospital operated for profit than to a nonprofit hospital providing the exact same services at the exact same cost in the same community. It is our view that evenhanded treatment—that is, a return on equity for nonprofits as well as for-profit hospitals—must be an essential part of any reimbursement system.

Chairman JACOBS. Thank you.

Mr. Duncan?

Mr. DUNCAN. I have no questions. Thank you.

Chairman JACOBS. Ms. Casber?

Ms. CASBER. No questions.

Chairman JACOBS. We thank you for the contribution. We take you up on your offer, sir, to help the committee in case there will be a combination between this bill and the social security bill. That remains as yet unknown, whether that will take place.

Mr. STROGER. Mr. Chairman, I would like to say that I would like as a lawyer to see the provisions put in there that would give not only administrative review to the rate, if this is enacted, but also give judicial review of the rate setting mechanism to any hospital. I speak not only as a member of the Cook County Board, but I am also deeply involved in the private hospital in our community, Community Hospital, and I think this would be a fair method.

Chairman JACOBS. Thank you, sir.

Our next panel consists of American Federation of Labor and Congress of Industrial Organizations, Bert Seidman, director, department of social security, and Robert M. McGlotten, associate director, department of legislation; American Association of Retired Persons, James M. Hacking, assistant legislative counsel for Federal legislation; National Council of Senior Citizens, William R. Hutton, director.

Mr. Seidman, you are first.

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

Mr. SEIDMAN. Thank you, Mr. Chairman. My name is Bert Seidman. I am director of the department of social security of the AFL-CIO.

I have a detailed statement and a summary, and I will summarize my summary but I request that the detailed statement and the summary be included in the record of the hearing.

Mr. Chairman, the AFL-CIO is pleased to have this opportunity to present its views on prospective budgeting as a solution to the serious problem of medicare inflation. Mr. Chairman, Wilbur Cohen, chairman of Save Our Security, has authorized me to say that the views we will present are fully supported by that coalition of more than 140 organizations, including the AFL-CIO.

Organized labor has long been concerned about uncontrolled increases in hospital costs. We vigorously supported comprehensive cost containment when it was under consideration by the Congress, and have given strong support to such efforts as statewide cost containment systems and controlling costs through collective bargaining and local health care coalitions.

Conservative theorists believe skyrocketing increases in medicare inflation can be reduced dramatically by making patients more cost conscious. We hope the committee will not be persuaded by this unfounded rhetoric, and will look at the facts. For cost consciousness is a clever euphemism for less coverage and higher out-of-pocket payments for beneficiaries while the real decisionmakers in the health care system, namely hospitals and physicians, continue to increase costs and raise fees without restraint.

The modest and deserved wage increases some hospital workers have been able to obtain have had little or nothing to do with hospital cost inflation. Until the providers and suppliers of health services have real incentives for cost effective behavior, as a nation we will continue to pay a great deal more for less.

We believe a cost containment system ought to apply to all payors and include all providers including physician services. Most important, it should not worsen the already unequal balance between the haves and the have-nots in health care.

Organized labor supports the administration's plans to introduce the concept of prospective budgeting into the medicare system, and to prevent hospitals from passing on to medicare beneficiaries any reductions in reimbursement. However, we believe the jury is still out on the New Jersey system based on diagnosis related groups, DRG's, which has been the model for this proposal.

Although the proposed plan may in some respects be an improvement over the present system, there is no evidence it will meet the administration's expectations of reduced costs, improved program efficiency, and protection for beneficiaries. In fact, the opposite may be true. A far better course would be enactment of a comprehensive, all-payors cost containment system along the lines of the HALT proposal developed by the Health Security Action Council. Such a system would allow States meeting Federal performance standards to make their own decisions about which form of prospective reimbursement should be used by all insurers including medicare.

The AFL-CIO has five areas of major concern about the administration's DRG proposal:

One, its potential to increase medicare costs as a result of incentives which exist in the system, to increase admissions to hospitals, and to place patients in the highest possible DRG's, so-called DRG creep.

Two, the potential for any medicare only cost containment system to transfer to already overburdened employers, employees, and State and local governments excess costs incurred under medicare.

Three, the treatment of public and inner city hospitals, which are the medical facilities of last resort for the poor, the elderly, and jobless workers without health insurance coverage. Unlike New Jersey, which has aided inner city and public hospitals by including in its DRG rates an allowance for bad debt and charity, HHS apparently has no plans to do so.

Four, permitting hospitals to pass through teaching and capital costs despite their inflationary impact.

Five, higher costs for HMO's which would not be rewarded for preadmission testing or their lower than average lengths of stay.

If the committee adopts a DRG model for medicare reimbursement, it should include strong utilization controls, an adjustment to compensate public hospitals for the higher costs associated with their patients, controls on capital expenditures, and outpatient services, and special provisions to assure that the new system does not increase the cost of HMO's.

In addition, we strongly urge you to reject the administration's recent proposals which would place significant financial burdens on beneficiaries.

The present problems associated with high inflation, reduced access and uneven quality of care would not exist had Congress enacted national health insurance as the AFL-CIO has long recommended and continues to advocate. But short of that goal, Congress should immediately enact a comprehensive cost containment program for all payors and including physician services.

Thank you, Mr. Chairman.

Chairman JACOBS. Thank you.

[The prepared statement follows:]

STATEMENT BY BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

SUMMARY

The AFL-CIO is pleased to have this opportunity to present its views on prospective budgeting as a solution to the serious problem of Medicare inflation. Organized labor has long been concerned about uncontrolled increases in hospital costs. We vigorously supported comprehensive cost containment when it was under consideration by the Congress and have given strong support to efforts to enact statewide cost containment systems. Our affiliates and local unions have made major efforts to control rising costs through collective bargaining and participation in local health care coalitions. We would like to submit for the record our full statement and proceed now to summarize our concerns with respect to the Administration's proposal to reimburse hospitals under Medicare on the basis of so-called diagnostic related groupings (DRGs).

Conservative theorists blame patients for the current health care crisis. They believe that skyrocketing increases in Medicare inflation can be reduced dramatically by making individuals more "cost-conscious." We hope the Committee will not be persuaded by this unfounded rhetoric and will look at the facts. For "cost-consciousness" is a clever euphemism for less coverage and higher out-of-pocket payments for beneficiaries, while the real decision makers in the health care system, namely hospitals and physicians, continue to increase costs and raise fees without restraint. Unless we can bring inflation under control, there will be no end to rising expenditures. Furthermore, the modest and deserved wage increases some hospital workers have been able to obtain have had little or nothing to do with hospital cost inflation.

The AFL-CIO urges this Committee to be skeptical of the assertions of individuals who blame our current health care crisis on those who work in and are served by the health care system. For until the providers and suppliers of health services have real incentives for cost effective behavior, as a nation we will continue to pay a great deal more for less.

For some years the AFL-CIO has thought the health care system poorly managed and that incentives which would make hospitals more cost-conscious ought to be added to public and private health insurance programs. However, we believe a cost containment system ought to apply to all payors and include all providers, including physician services. In addition, and perhaps more important, no cost containment system should worsen the already unequal balance between the haves and the have-nots in our system.

Organized labor supports the Administration's plans to introduce the concept of prospective budgeting into the Medicare system and to discontinue the practice of paying hospitals whatever they spend. We fully support the Administration's decision to prevent hospitals from passing on to Medicare beneficiaries any reductions in reimbursement. However, we believe the jury is still out on the New Jersey system based on diagnosis related groups (DRGs), which has been the model for this proposal. We do not know enough about the effectiveness of this approach to adopt it immediately for Medicare. In addition, there are many problems associated with implementing a DRG system that the proposal does not address.

Although the proposed plan may in some respects be an improvement over the present system, there is no evidence it will meet the Administration's expectations of reduced costs, improved program efficiency and protection for beneficiaries. In fact, the opposite may be true. Without strong utilization controls in the proposed system, Medicare costs could increase. A prospective reimbursement system for Medicare alone would give hospitals strong incentives to turn away all, or certain types of, Medicare patients and could also encourage facilities to shift unreimbursed costs onto employees, employers and already overburdened state and local governments. A far better course would be enactment of a comprehensive all-payors cost containment system along the lines of the HALT proposal developed by the Health Security Action Council. Such a system would allow states meeting federal performance standards to make their own decisions about which form of prospective reimbursement should be used by all insurers, including Medicare, to reimburse providers. Organized labor is ready and willing to work with the Committee to enact such a plan.

The AFL-CIO has five areas of major concern about the Administration's DRG proposal:

1. Its potential to increase Medicare costs as a result of incentives which exist in the system for physicians to place patients in the highest possible DRGs (so-called "DRG creep").

2. The potential for any Medicare only cost containment system to transfer to already overburdened employers, employees and state and local governments excess costs incurred under Medicare.

3. The treatment of public and inner city hospitals, which are the medical facilities of last resort for the poor, the elderly and jobless workers without health insurance coverage. Under the DRG system hospitals are compensated only for a patients primary diagnosis; therefore, facilities such as public and inner city hospitals, which treat patients who are proportionately sicker and have more complicated conditions might not be adequately compensated for the additional services they provide.

4. The Administration's proposal would allow hospitals to pass through teaching and capital costs, despite the significant role these expenditures have played in increasing the cost of medical care.

5. The DRG proposal would mean higher costs for HMOs, which would not be rewarded for preadmission testing or their lower than average lengths of stay.

If the Committee adopts a DRG model for Medicare reimbursement it should include: strong utilization controls; an adjustment to compensate public hospitals for the higher cost associated with their patients; controls on capital expenditures; outpatient services and special provisions to assure that the new system does not increase the cost of HMOs.

The AFL-CIO urges the Committee to avoid these problems by adopting a prospective reimbursement system for all payors, public and private, with flexibility for states to design their own sytems so long as they meet federally established guidelines. In addition, we urge you to reject the Administration's recent budget proposals which would place significant financial burdens on beneficiaries. For example, the average widow on social security would have to spend almost $600 out-of-pocket for an average hospital stay, which amounts to almost two months of her social security benefits. The same individual would be required to pay 20-25 percent of her annual cash benefits before being eligible for catastrophic care.

A far better course, which would reduce Medicare expenditures in the long run, would be to lower cost-sharing beneficiaries that are required to pay for outpatient physician services and to expand Medicare benefits to cover drugs, dental care and other services. Such steps would keep older people healthier and reduce their need for hospital care.

The present problems associated with high inflation, reduced access and uneven quality of care would not exist had Congress enacted national health insurance, as the AFL-CIO has long recommended. We will continue to work toward the goal of national health insurance. But organized labor believes we cannot wait to bring health care inflation under control. We urge Congress to immediately enact a comprehensive cost containment program for all payors and including physician services. We also urge Congress to reject the Reagan Administration's proposed budget cuts in the area of health care, which would penalize beneficiaries, encourage them not to seek health care treatment while allowing the providers and suppliers of services to increase costs at uncontrollable rates.

STATEMENT

The AFL-CIO is pleased to have this opportunity to present its views on prospective budgeting as a solution to the serious problem of Medicare inflation. Organized labor has long been concerned about uncontrolled costs. We vigorously supported comprehensive hospital cost containment when it was under consideration by the Congress and have given strong support to similar efforts in state capitols. Our affiliates and local unions have made major efforts to get a handle on this problem through collective bargaining and participation in local health care coalitions. We commend you for convening hearings expeditiously on the Administration's plan to base reimbursment of hospitals on the cost of treatment provided to each patient. However, since there has been so much discussion and little agreement on the nature of the so-called "Medicare problem," I would like to make some general comments before discussing any of the proposed remedies.

HEALTH CARE COSTS

Hospital care is the largest (42 percent) and most rapidly expanding category of national health expenditures. For the past 6 years hospital costs have risen at an annual rate more than two times greater than increases in all other goods and services in the general economy. This rapid growth in hospital costs has had a profound effect on the Medicare program. Approximately two-thirds of total Medicare expenditures are paid to hospitals, which explains why outlays for the program are rising at an annual rate of almost 20 percent. It also explains the growing pressure to bring inflation in the Medicare program under control.

Conservative theorists blame patients for the current health care crisis. They believe that skyrocketing increases in Medicare inflation can be reduced dramatically by making individuals more "cost-conscious." We hope the Committee will not be persuaded by this unfounded rhetoric and will look at the facts. For "cost-consciousness" is a clever euphemism for less coverage and higher out-of-pocket payments for beneficiaries, while the real decision makers in the health care system, namely hospitals and physicians, continue to increase costs and raise fees without restraints.

There are three factors which determine the level of health care inflation in a given year: price, utilization and intensity. According to the Health Care Financing Administration, during the period 1967-1978 inflation accounted for 50 percent of the annual increase in Medicare costs. The next largest category (36 percent) was intensity of services, such as improvements in technology. Contrary to the commonly held view, non-labor costs account for 70 percent of the figure. Increases in the Medicare population account for 12 percent. The smallest category (1.9 percent) was utilization, which reflected increased demand. The problems which must be solved, therefore, are how to reduce the price of medical care and change incentives within the current reimbursement system which encourage unnecessary testing and other procedures. Despite present efforts to reduce Medicare coverage, unless we can bring inflation, excessive testing and unnecessary surgery under control, there will be no end to rising expenditures.

In this connection, Mr. Chairman, I would like to address an issue which is repeatedly misrepresented. That is, the impact health care workers have on health care costs. Most health care workers have been and continue to be, underpaid. According to the Bureau of Labor Statistics, non-suspervisory health care workers earn almost 15 percent less than workers in other industries. Their real income has been declining and in 1980 was 6 percent lower than in 1972. In effect, hospital workers have been unfortunate scapegoats for the real villains in the health care system. Everyone in this room has heard workers being blamed for health care inflation. Yet from 1965 to 1980 wages, as a percent of total expenses in community hospitals, declined from 62 to 49 percent. Contributions for fringe benefits also declined.

The point is there are no easy answers to the problem of rising health care costs. Mr. Chairman, the AFL-CIO urges this Committee to be skeptical of those who blame our current health care crisis on those who work in and are served by the health care system. For until the providers and suppliers of health services have real incentives for cost effective behavior, as a nation we will continue to pay a great deal more for less.

REIMBURSEMENT OF HEALTH CARE PROVIDERS

For some years the AFL-CIO has thought the health care system poorly managed and that incentives which would make hospitals more cost-conscious ought to be added to public and private health insurance programs. However, we believe a cost containment system ought to apply to all payors and include all providers, including physician services. In addition, and perhaps most important, no cost containment system should worsen the already unequal balance between the haves and the have-nots in our system.

Organized labor supports the Administration's plans to introduce the concept of prospective budgeting into the Medicare system and to discontinue the practice of paying hospitals whatever they spend. We regard the proposal as an improvement over the present practice in Medicare of rewarding inefficient hospitals and penalizing facilities which have tried to contain costs. We fully support the Administration's decision to prevent hospitals from passing on to Medicare beneficiaries any reductions in reimbrusement. We do not believe a nationwide system based on so-called diagnostic related groups (DRGs) is the best answer. We believe the jury is still out on the New Jersey system, which has been the model for this proposal. We do not know enough about the effectiveness of this approach to adopt it immediately for Medicare. In addition, there are many problems associated with implementing a DRG system that the proposal does not address.

In the Executive Summary of the Administration's report to Congress outlining its DRG proposal there are listed four goals which the program is expected to accomplish: (1) improve hospital efficiency; (2) make Medicare a prudent buyer of services; (3) reduce administrative burdens; and (4) assure beneficiaries access to quality health care. Although the proposed plan may in some respects be an improvement over the present system, there is no evidence it will meet these expectations. In fact the opposite may be true. Without strong utilization controls in the proposed system, Medicare costs could increase. Unless outpatient services are included, the Administration's plan will only add to hospitals' already cumbersome paperwork requirements by requiring hospitals to keep one set of books for outpatient services and another separate set for inpatient services.

A prospective reimbursement system for Medicare alone would give hospitals strong incentives to turn away all, or certain types of, Medicare patients. We agree with the insurance industry that it could also encourage facilities to shift unreimbursed costs onto employees, employers and already overburdened state and local governments. A far better course would be enactment of a comprehensive all-payors cost containment system, which would allow states meeting federal performance standards to make their own decisions about the system of prospective reimbursement which should be used by all insurers, including Medicare, to reimburse providers. I will go into greater detail about the structure of such a program later on in my testimony. At this time I would like to list organized labor's concerns about the Administration's DRG proposal.

PROBLEMS ASSOCIATED WITH DRGS

Cost of the plan

Several months ago the Wall Street Journal published a story evaluating New Jersey's experience with DRGs. The President of the New Jersey Hospital Association, Louis Scibetter, described the system as an "administrative nightmare," which was not cost-effective. A 1981 survey of the first 26 hospitals to enter the system indicated that most administrators could not determine whether the new system was having a positive effect on health care costs. In fact, 40 percent of statewide hospital claims are now paid on the basis of exceptions which does not bode well for the efficacy of a DRG system.

A major concern with the Administration's proposal is whether it will result in higher Medicare costs. The DRG system involves placing patients for purposes of Medicare reimbursement into one of 467 diagnostic categories. This involves a great deal of discretion on the part of physicians who would be making these decisions and would encourage physicians to put patients into the highest possible category, a phenomenon which has come to be known as "DRG creep." The Administration claims it can prevent this but has not proposed any specific plan for utilization review. Therefore, it would be extremely difficult to monitor the system or develop ways to assure that this practice does not increase costs.

Cost shifting

As efforts to control increases in health expenditures under public programs have increased, hospitals have had stronger financial incentives to transfer to other payors excess costs incurred under Medicare. In recent testimony before the Social Security Advisory Council the American Hospital Association acknowledged that many facilities have no alternative but to shift costs onto those covered by private insurance. In other words, the government has been reducing federal outlays for Medicare at the expense of financially overburdened working men and women and state local governments. The insurance industry has estimated that in Minneapolis cost-shifting has added $33 per day to the cost of an average hospital stay.

The open-ended reimbursement system under private insurance which the Administration's proposal would not affect allows cost-shifting to take place. Hospitals have no incentive to become more efficient as long as they can cover their Medicare losses by charging non-public patients more.

Public and inner city hospitals

The AFL-CIO and its affiliates are very concerned about the effect of the Administration's proposed prospective payment plan on public and inner city facilities. Public hospitals have proportionately more older and sicker patients and are the providers of last resort for patients whom other hospitals refuse to treat. In recent years public hospitals have had to absorb the cost of treating a growing number of individuals who have lost health insurance coverage as a result of layoff. In many communities public and inner city hospitals are the only providers of tertiary care, such as burn units and trauma centers, and alcoholism and drug abuse treatment. These facilities are key providers of primary care and the training ground for 40 percent of all physicians and dentists. Most important, public hospitals are the medical facilities of last resort for the poor, the elderly and the jobless. Their role in the current economic recession in more important than ever.

Despite the range of health services they offer and their important role as community providers, the financial position of public hospitals is deteriorating rapidly. Yet, in terms of standard measurements of efficiency, they are far ahead of other hospitals. Inflation for public hospitals is 33 percent less than the rate of increase for all other facilities. According to Larry Gage, Executive Director of the Public Hospital Association, these facilities have reduced their lengths of stay, have increased occupancy and have reduced their bed supply by 22 percent from 1970 to 1980.

Rather than rewarding these essential community providers for their efficiency, the Administration's DRG proposal would only worsen their bleak financial situation. Public hospitals serve a patient population which requires more admissions, longer lengths of stay and greater intensity of services. Since DRGs are based on average costs per diagnosis, public hospitals which serve a relatively large number of patients with multiple conditions and/or complications and therefore higher costs, will be penalized. Nor will they be able to cope with growing demand as a result of more people losing coverage due to layoff.

Public hospitals do not dump patients who are expensive to treat on other hospitals. They serve all patients who need care, regardless of their ability to pay. At the same time their support from federal, state and local governments is declining. Clearly a comprehensive long-term strategy must be developed for our public hospitals. Both Medicare and Medicaid reimburse hospitals for capital costs. Non-public hospitals have used these funds to expand and modernize their facilities and equipment. Public hospitals are more likely to use these funds to cover operating deficits which are four times higher than those in private facilities. In the short run there are important steps that Congress can take to assure that any changes made in the Medicare reimbursement system do not unfairly penalize essential community providers.

In Section 101 of the Tax Equity and Responsibility Act, the Secretary of HHS was authorized to make adjustments in reimbursement to public and inner city hospitals. To date the Department has not implemented this adjustment but has spent its time trying to prove whether it is needed. Meanwhile more and more of these facilities are approaching bankruptcy. Congress should immediately pass legislation instructing the Secretary to give facilities which serve higher than average numbers of Medicare and Medicaid patients a special allowance. This adjustment should also be incorporated in any long-term prospective system. An all-payor prospective reimbursement system, which included a bad debt and charity allowance, would also relieve the financial burden on public hospitals.

Teaching and capital costs

The Administration's proposal would allow hospitals to pass through teaching and capital costs. Yet these are areas that have played a significant role in increasing the cost of medical care. Certainly hospitals need capital allowances. However, unless the reimbursement system provides incentives to economize in this area, no significant savings will be achieved.

HMO's

The DRG program would mean higher costs for HMOs. Since hospitals would be paid on the basis of average costs, there would be no rewards for preadmission testing or reduced lengths of stay. In fact, available evidence indicates that in New Jersey since the advent of the DRG system, HMOs have had to make higher payments to hospitals for the same services than before DRG came into effect.

If the objective is to reduce Medicare expenditures, we should accomplish this without increasing the costs of effective alternative delivery systems. Organized labor recommends, therefore, that HMOs which can demonstrate cost-effectiveness ought to be exempted from the prospective budgeting system.

RECOMMENDATIONS

The AFL-CIO urges the Committee to adopt a prospective reimbursement system for all payors, public and private, with flexibility for states to design their own systems as long as they meet federally established guidelines. Organized labor fully supports the HALT proposal developed by the Health Security Action Council (HSAC). This proposal is attached to our testimony for your review.

As the Committee examines alternatives to the present method of paying hospitals and the factors which contribute to 20 percent annual increases in Medicare expenditures, we urge you to also look at the adequacy of the Medicare benefit package.

In addition to its DRG proposal, the Administration has recommended increasing beneficiary cost-sharing as a way of bringing Medicare inflation under control. Since physicians decide who goes into hospitals, how many tests they have and when they are discharged, there is a great deal of uncertainty as to whether the Administration's budget proposals, if adopted, would save money. There is no doubt, however, that these proposals would be a cruel blow to senior citizens who have already been asked to accept a six month delay in their cost-of-living (COLA). For example, the average widow on social security would have to spend almost $600 out-of-pocket for an average hospital stay, which amounts to almost two months of her social security benefits. The same individual would be required to pay 20-25 percent of her annual cash benefits before being eligible for catastrophic care.

A far better course, which would reduce Medicare expenditures in the long run, would be to lower cost-sharing beneficiaries are required to pay for outpatient physician services and to expand Medicare benefits to cover drugs, dental care and other services which keep older people healthier and reduce their need for hospital care.

CONCLUSION

The present problems associated with high inflation, reduced access and uneven quality of care would not exist had Congress enacted national health insurance, as the AFL-CIO has long recommended. We will continue to work toward the goal of national health insurance. But organized labor believes we cannot wait to bring health care inflation under control.

We also urge Congress to reject the Reagan Administration's proposed budget cuts in the area of health care, which would penalize beneficiaries and discourage them from seeking needed health care teatment while allowing the providers and suppliers of services to increase cost at uncontrollable rates. Instead we urge Congress to immediately enact a comprehensive cost containment program for all payors and including physician services.

THE HEALTH SECURITY ACTION COUNCIL: HEALTH CARE COST CONTAINMENT—A CONSTRUCTIVE APPROACH

The program herein outlined is a major alternative to the cuts in health programs proposed in the President's Budget.

Labor, business, civic, fraternal, religious, senior citizen and farm organizations, as well as, national and local political leadership agree that skyrocketing health care costs must be brought under control. Last year health costs increased 15.3 percent over the previous year. This was the highest in our history. This is unacceptable.

This is a national problem. It is not only a problem for the public sector. It is a problem for the private sector as well.

The Administration's approach would again slash Medicare and Medicaid programs, wiping out vital services for millions of children, the disabled and the elderly, while simultaneously shifting the cost of their care to the rest of the economy.

In addition they have been proposing a so-called "competition" proposal. It claims to offer control of health care costs by placing a ceiling on employer and/or employee payments for health insurance. But this plan would not contain costs. It would shift them, through reducing health coverage and transferring charges from insurance to consumers and patients. A tax gimmick would be used to abandon hard-won, high option health insurance plans for lower-grade coverage. A variant of the plan, involving Medicare vouchers, would diminish already inadequate health care protection for millions of elderly and severly disabled persons.

As a national problem, skyrocketing health care costs demand a national solution. Although a comprehensive national health insurance program would be the best solution, it is not a politically viable one for 1982.

Consequently, the next best solution is equitably to control and rationalize health care spending within our present insurance system. Such a program would require equal constraints on the public and private sector, and on the providers and insurers of services.

This solution would deal with all of the principal elements of the health care system. Moreover, it would decentralize many of the critical health cost containment decisions to the state level, with the federal government providing broad guidelines, standards and technical support. If a state is unable to undertake such a program, the federal government could make it available.

In the name of cost containment the Administration is proposing to reduce the federal deficit by shifting billions of dollars from the federal government to patients, doctors, hospitals, private insurance, and already overburdened state and local governments. This approach will not contain costs; it will only cause added suffering and death due to slashed services and entitlements.

There is a better way, a more humane approach, that will protect people *and* save money. That is why a new comprehensive alternative to the Administration's plan is being proposed. It would put an immediate brake on health cost escalation, while a new series of state controls, based on prospective budgets and negotiated agreements with providers, insurers and other payors are put in place.

The program will save an estimated five and a half billion dollars in public expenditures in each of the first two years of operation. Of these savings, some one and a half billion dollars would be returned to the states as incentive payments under Medicaid.

The private sector would also benefit. It would be expected to spend annually some seven and a half billion dollars less, without reducing benefits, under this plan, than if the Administration's proposals were adopted.

The new program can effectively begin to produce needed changes, and at the same time protect the consumer. Drafted by an advisory group of professional and technical experts, it contains the following principal features:

1. Comprehensive cost containment across the entire system—public and private, including hospitals, nursing homes and professional providers of health services.
2. State responsibility and flexibility in the cost control process, combined with prospective budgeting and ceilings on hospital and nursing home payments, based on the previous year's expenditures plus increases allowed for the rate of inflation in the economy.
3. In the first 2 years of the plan the state ceiling would be set by the state in accordance with the previously enunciated principle. This would almost cut in half the rate of escalation of health care costs. Further, it would assure the continuation of the present benefits and entitlements of public programs.
4. Physicians and other professional providers' reimbursements would initially be held to current levels, plus an allowance for inflation in cost of office overhead. Providers could not charge above negotiated reimbursement rates for in-hospital and nursing home services ("assignment").
5. Laboratory and X-ray services would be reimbursed on a negotiated rate schedule worked out among representatives of the public agencies, Medicare intermediaries, providers, insurance companies, consumers, and the laboratories and X-ray organizations.
6. The organization of new health maintenance organizations would be encouraged.

7. A national expert committee would advise the professions and the payors on new procedures and new technology.

8. New programs for more effectively meeting the long term care needs for the elderly and disabled would be encouraged.

Details of the specific proposals are contained in the section which follows.

Hospitals

Since hospitals are the largest single source of personal health expenditures, public and private, control of the increase in their costs would be central to the new comprehensive health cost containment system.

The principal feature of the new program would be a state prospective budgeting system with annual ceilings for both hospitals and nursing homes. Together they constitute almost half of current payments for personal health services. The total budget for state expenditures for hospitals, public and private, but excluding state mental hospitals, would be based on: (a) the last year's total expenditures; or (b) a typical year in the last three years; or (c) the average of the previous three years' expenditures. This would be adjusted by the increase in the Consumer Price Index in the past year.

The percentage increase allowed would be uniform for both public and private sector payment of costs and/or reimbursement. The Federal and state governments would continue to receive discounts which derive from their positions as the major purhasers of hospital services.

Each of the principal payors for hospital care, including Medicare and Medicaid, would be limited in its payments by its previous proportion of hospital care payments to total state spending for hospital care. Annual adjustment would be made for the number of persons enrolled in the programs, their age and health status. The uninsured and others paying out-of-pocket for hospital care would pay directly to the hospital involved with appropriate credit given in hospital budgets for such payments.

Federal Medicare and Medicaid funds would provide the leverage for the new system in each state. The law would require however that private insurance payments, including Blue Cross, would be mandated for inclusion in each state program.

Medicare would continue as a Federal program with full control on eligibility and benefits, and through intermediaries, would continue to monitor program operations to assure the proper implementation of Federal law and policies.

The key to cost control would be however with the states which are closer to the actual delivery system and in a better position to see that the system is both cost efficient and effective.

The states could, as long as they remained within the predetermined ceilings, use their own methods of determining how to pay hospitals within the system. This could be done in a variety of ways: prospective budgeting by category of hospital (e.g. teaching hospital, small, medium or large community hospital, rural hospital, etc.); formulae to set limits on what could be charged various payors; budget reviews of each hospital; capitation payments for defined populations.

State flexibility in adopting their own budgeting plans would be assured, so long as they were based on prospective budgeting and annual predetermined ceilings.

Representatives of health workers would participate in the statewide reimbursement negotiations on an equal basis with hospitals and nursing home officials and the plan would protect collectively bargained rights and benefits for employees.

A State agency, either responsible to the governor directly, or as a semi-autonomous unit in the State Health Department, would manage the program and be responsible for negotiations with the hospitals and the insurers and would provide for adequate consumer representation.

Each state would be required, within 120 days of passage of federal legislation establishing the program, to file with the Department of Health and Human Services notice of intent to operate the cost containment plan. The state would enact implementing legislation. Its plan would be subject to approval by the Department of Health and Human Services.

There would be a federal appeal mechanism which the state could use in the event of disagreement regarding Federal plan approval. Similarly there would be a state appeal mechanism for hospitals and payors (insurance companies, Blues, HMOs) which may have disagreements with the state administrative agency.

Savings from the negotiated budget would be shared by the hospitals, public and private payors. Consumers would participate in the savings through improved services and lower insurance premium rates made possible by hospital cost savings.

Prospective budgeting is a simpler way of reimbursing hospitals than the currently prevailing cost reimbursement system. Therefore, it should yield considerable savings in lowered administrative and recordkeeping costs. At least part of these savings may be required for added allowances for hospitals which serve disproportionately large numbers of the medically indigent for whom no (or reduced) public payments are available.

In negotiating the annual prospective budget the parties would be expected to take into account the need for reduction in duplicate services and excess plant capacity, as well as appropriate planning for changes in technological and physical resources.

States which participate in the program would have the incentive of an approximately 10 percent reduction in their contributions of Medicaid funds in the coming year. These reductions would be financed from the reimbursement savings engendered by the operation of the cost containment plan.

Since it would in all likelihood take a year or more to make this health care cost containment program fully operative, hospitals would be required to operate for 24 months under a fixed reimbursement formula, adjusted for inflation, as described earlier. Charges and cost reimbursement per patient and charges per procedure in the first year would be fixed at the mean of similar charges for the hospital in the previous 12 month period, plus the increase in the Consumer Price Index for the same period. A further adjustment in reimbursement would allow for any increases in the wages and benefits of non-supervisory employees during the transition period.

In the second year increases up to two-thirds of the increase in the CPI for the previous year would be permitted.

Hospitals could shorten the period of fixed reimbursement rates to 12 months in any state where the plan could be readied for operation in a period less than 24 months.

Nursing homes

Nursing homes and intermediate care facilities continue to require major and increasing expenditures from Medicare and Medicaid as well as private sector programs. Despite the fact that some 80 percent of the beds are operated by private for-profit owners, competition has not played a meaningful role in containing increases in costs.

Cost containment is essential, but it must not jeopardize decent staffing and facility standards. Unless adequate standards are maintained, quality of care and competence of staff would be eroded.

Accordingly, the state agency charged with administering the hospital program, along with the Medicare intermediary, would also be required to see that existing Federal and state standards are observed within the same prospective budgeting limits as are required of hospitals.

Provisions which apply to hospitals with regard to negotiation of budgets, appeals, savings from budget, employee protections and the maximum 24 months restriction on price increases would apply to nursing homes and intermediate care facilities.

In negotiating the annual prospective budget the parties would be expected to take into account the need for reduction in duplicate services, excess plant capacity, and appropriate planning for expansion of technological and physical resources.

Physicians and other providers

Existing reimbursement methods contribute to inflated health care costs by encouraging procedures and discriminating against services that do not involve technology. They fuel cost increases by reimbursing on the basis of charges that are not the result of negotiation among payors, patients and providers.

Under the Health Care Cost Containment Plan, third party payors, including states, insurance companies and third party intermediaries in behalf of Medicare, organized labor, representatives of the public, and representatives of physicians and other independent health professionals would negotiate annual fee schedules or alternative payment arrangements that would be used for reimbursement.

Initially fee schedules would be set at present levels in each of the three programs in the state (Medicare, Medicaid, private insurance). A single level fee schedule is obviously preferable, but would probably be too costly to the public programs in the initial and transition stages. Hopefully, over time, through joint efforts of the parties involved in the state negotiations, movement would be made toward a single schedule or reimbursement arrangement which would be equitable for providers and payors.

Incentives would be built into the payment structure to encourage primary care, disease prevention, and health promotion, and to give appropriate compensation for treatments which are time and process oriented.

The Health Care Cost Containment Program would mandate "assignment" for in-hospital and nursing home services. Providers could not charge above negotiated reimbursement rates. Professional services delivered in these institutions, as well as their nature and frequency, are sufficiently different from ambulatory services to require both a different payment structure and one that reflects total payment.

Since it would in all likelihood take a year or more to make the health provider cost containment program fully effective, states would be authorized to provide for no increases in rates of reimbursement for health providers for a twenty-four month maximum period, except for an allowance for increased overhead costs reflecting the year's inflation rate. Provision would be made for relaxation of these fixed rates after one year if in any state the system could be placed in operation sooner.

Third party payors and the health professionals should be encouraged to develop capitation and other payment arrangements and to be reimbursed on other than a fee-for-service basis. It would be appropriate and desirable for payors, patients and providers to benefit from these savings.

In arriving at appropriate reimbursement schedules due recognition should be given to the cost experience of the previous three years, to adjustment necessary because of anticipated inflation, changes in demographic characteristics of states and local areas, etc.

Payment mechanisms or fee schedules arrived at through negotiation are not deisgned to reduce compensation of health professionals, but to begin the process of instituting cost increase restraints.

Existing payment patterns in Medicare and some private insurance programs (particularly indemnity insurance) do not provide for full payment for professional services. Accordingly these underpayments are made up by out of pocket payments by patients. Provisions would be made in state requirements that such out of pocket payments coud not be increased to make up for the constraints in reimbursements in professional fees.

Laboratory and X-ray services

Each state would appoint a laboratory and X-ray payment committee under the Health Care Cost Containment Agency. It would be composed of representatives of the public agency, Medicare, providers, insurance companies, consumers, and the laboratory and X-ray providers. Fee schedules would be developed annually and payments made on this basis. The Committee would be empowered to review appropriateness and frequency of the procedures and technology used.

Health maintenance organizations

Separate contracts would be neogitated with HMOs offering them maximum reimbursement up to previling costs in the area adjusted by age and health status. The objective would be to avoid selective enrollment of favorable risks.

Unions, employers and insurers would be encouraged to organize new HMOs. Partial forgiveness, up to a stipulated maximum of first year organizing costs of new non-profit HMOs would be provided through provision for write-off as a business expense, or payment of an extra 5 percent in premiums in each of the first three years of operation.

New procedures—new technology

New procedures and new technology have brought important health benefits to millions of Americans. To reduce future costs by denying the fruits of research to future patients is unconscionable. But the fact is that unless we find ways of assuring that new procedures are paid for only when they are appropriately used and that less efficacious procedures are phased out, we will find ourselves unable to finance desirable advances.

The issue of appropriate use of new procedures can, in part, be addressed through fee schedules and other organized payment arrangements. But the refined information needed must be of the highest quality, and the decisions to be taken require professional concensus and acceptance. The national program will therefore authorize organization of a Professional Advisory Committee on New Procedures and Technology sponsored by the Institute of Medicine of the National Academy of Sciences, or within the Department of Health and Human Services, and supported by existing professional bodies. This committee would be given the responsibility to examine the appropriateness of various interventions and the conditions under which they are needed. The efficacy of alternative theraputic regimens, the standards for availability and utilization of various technologies would be reviewed and commented on. The Committee's reports would be advisory to the health professions, administrators of institutions, payors, and those who negotiate payment schedules and prospective reimbursement.

Long term care

Meeting the needs for long term care for significant numbers of people, particularly the elderly, continues to be a vexing, expensive and largely unmet issue in health care and in social services.

There is widespread agreement that present patterns of services are often inappropriate, and unduly costly.

Proposed solutions which do not involve large new expenditures are not readily apparent. There is however considerable agreement on at least two principles: (1) Many more chronically ill and severely disabled could and should be cared for at home if appropriate services could be brought to them. Experienced personnel in institutions should be used for many of these home care services. (2) The chronically ill and severely disabled could and should have available to them a combination of health and social services which the present compartmentalization of public programs makes it difficult, if not impossible, to provide.

Accordingly it is proposed that the health care cost containment plan authorize states desiring to do so, to take up to a stipulated percentage of Title XX funds and a percentage of Medicaid funds, to support demonstration projects designed to maintain the chronically ill and severely disabled outside institutions. Continuity of care should be safeguarded through delivery of many of the services by institutional personnel with appropriate contractual protections. Plans like "social HMOs" or "personal care organizations" would thus be encouraged to develop more progressive and possibly cost effective patterns of long term care. Such demonstration projects are more likely to prove meaningful when developed at the local level by knowledgeable people with understanding and a caring attitude about the problem.

In conclusion

This Health Care Cost Containment Plan is realistic and achieveable within a reasonably short period of time. It would take courage on the part of the Congress to initiate it, for it represents a fresh approach to dealing with the escalation of costs of health care.

This plan would require formulation in legislation. Preliminary estimates of savings involved, however, are so substantial that full implementation would, in fiscal year 1983, make possible:

(1) Savings in Federal budget expenditures for Medicare, Medicaid and other personal health services programs comparable to those proposed by the Administration for fiscal year 1983. These, however, would be achieved without further slashes in eligibility or benefits.

(2) Beginning relief to the states of constantly increasing expenditures for Medicaid programs without further reducing eligibility or benefits. Approximately 1.5 billion dollars in relief to the states would be expected in each of the first two years.

(3) Some 7.5 billion dollars per year savings in insurance and out of pocket payments in the private sector in each year of this plan as compared with the continuation of the status quo.

(4) A return to the states of needed initative and authority to control health costs in their jurisdictions.

(5) A halt to cost shifting from federal programs to the private sector, to states and to patients and adequate protections for health care workers.

(6) The initiation of sound long range plans for continuing containment of health care costs in both the public and private sectors.

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February 10, 1982

The Honorable Andrew Jacobs, Jr., Chairman
Subcommittee on Health
Committee on Ways & Means
U.S. House of Representatives
1104 Longworth House Office Building
Washington, DC 20515

Dear Mr. Chairman:

It is our understanding that the American Federation of Labor and Congress of Industrial Organizations will be presenting testimony to the Subcommittee on Health, relative to the Administration's proposals for prospective payments under Medicare.

This is to inform you that the views which will be presented by the AFL-CIO are fully supported by Save Our Security.

SOS is a nationwide coalition of more that 140 organizations representing a cross-section of American life. I am attaching a list of the affiliated organizations to give you the full flavor of the coalition. There are organizations representing the elderly and the disabled, trade unions representing workers in the public and private sectors, social welfare groups, women's groups, civil rights groups and religious organizations. Together, these affiliated organizations have a membership of between 35 and 40 million adult Americans, almost equally divided between beneficiaries of, and contributors to, Social Security.

On behalf of Save Our Security, we wish to associate ourselves with the views expressedby the AFL-CIO, and respectfully request that this letter be made a part of the Subcommittee's hearing record.

Sincerely,

Wilbur J Cohen

Wilbur J. Cohen
Chair

WJC/as

AFFILIATED ORGANIZATIONS

A. Philip Randolph Institute
Action Alliance of Senior Citizens of Greater Philadelphia (PA)
Advocates for the Handicapped
Alton-Wood River (IL) Federation of Labor
American Association of Homes for the Aging
American Association of Retired Persons
American Association of University Professors
American Association of University Women
American Association on Mental Deficiency
American Coalition for Citizens with Disabilities
American Council of the Blind
American Ethical Union
American Federation of Labor/Congress of Industrial Organizations
American Federation of State, County and Municipal Employees
American Foundation for the Blind
American Jewish Committee
American Veterans Committee
Americans for Democratic Action
Armstrong, Clarion Counties (PA) Central Labor Union Council
Associated Actors and Artistes of America
Association for Retarded Citizens
Bakers, Confectionery and Tobacco Workers International Union
Cattaraugus-Allegheny Counties (NY) Central Labor Council
Center for Community Change
Center for Independent Living
Central Labor Union of Erie County (PA)
Central Maine Area Agency on Aging
Central Ohio Council of Senior Citizens
Cincinnati (OH) AFL-CIO Council
Communications Workers of America
Community Council of Greater New York
Concerned Seniors for Better Government
Congress of Senior Citizens of New York
Connecticut State AFL-CIO
Council of State Administrators of Vocational Rehabilitation
Democratic Socialist Organizing Committee
Disabilities Plus, Ink
Disabled American Veterans
Disabled in Action of Pennsylvania
Dunn County (WI) Central Labor Council
Economic Opportunity Commission
Edwardsville (IL) Central Trades and Labor Council
Federation of Senior Citizen Clubs and Organizations
Food Research and Action Center
Fund to Assure an Independent Retirement
Graham-Greenlee Union Club of Clifton (AZ)
Gray Panthers
Highland Valley (MA) Elder Service, Inc.
International Association of Bridge, Structural and Iron Workers
International Association of Machinists and Aerospace Workers
International Chemical Workers Union
International Ladies' Garment Workers Union
International Union of Operating Engineers
Joseph P. Kennedy, Jr., Foundation
Leadership Conference of Women Religious
Legal Research and Services for the Elderly
Massachusetts Association of Home Care Corporations and Area Agencies on Aging
Massachusetts Organization of Disabled Workers
Mechanics Educational Society
Metal Trades Department, AFL-CIO
Metropolitan Baltimore Council of AFL-CIO Unions
Metropolitan N.Y. Coordinating Council on Jewish Poverty
Monmouth County (NJ) Office of the Handicapped
Montana State AFL-CIO
Muskegon (MI) Labor Council
National Association for Human Development
National Association for the Advancement of Colored People
National Association of Private Residential Facilities for the Mentally Retarded
National Association of Retired Federal Employees
National Association of State Universities and Land Grant Colleges
National Black Catholic Lay Caucus
National Board of the YWCA
National Caucus and Center on Black Aged
National Center for Urban Ethnic Affairs
National Coalition for Older Women's Issues
National Conference of Catholic Charities
National Consumers League
National Council of Catholic Women
National Council of Churches
National Council of Jewish Women
National Council of La Raza
National Council of Negro Women
National Council of Senior Citizens
National Council on the Aging
National Education Association
National Farmers Union
National Indian Council on Aging
National Multiple Sclerosis Society
National Organization of Social Security Claimants Representatives
National Senior Citizens Law Center
National Society for Autistic Children
National Urban Coalition
National Urban League
National Women's Political Caucus
New Hampshire Association for the Elderly
New Horizons
Ohio Coalition of Senior Citizen Organizations
Ohio Rehabilitation Services Commission
Older Women's League
Operation Overcome of Lackawanna County (PA)
Operation Overcome of the Anthracite Region (PA)
Operation Overcome of the Lehigh Valley (PA)
Oswego County (NY) Labor Council
Ozaukee County (WI) Trades and Labor Council
Paralyzed Veterans of America
Pennsylvania Alliance of the Physically Handicapped
People United for Self Help
Power, Inc.
Retired Teachers Chapter, United Federation of Teachers
Retirees Union Club of Sierra Vista (AZ)
San Joaquin and Calaveras Counties (CA) Central Labor Council
San Mateo County (CA) Central Labor Council
Save Our Childrens' Security
Secure Our Children
Senior Citizens Task Force/United Planning Organization
Seniors for Adequate Social Security
Southeastern Oregon Central Labor Council
Student Services for the Handicapped
Texas Planning Council for Developmental Disabilities
Texas State AFL-CIO
The Workmen's Circle
UAW Retired and Older Workers Department
Union Club of Cottonwood/Verde Valley (AZ)
Union Club of Sun City (AZ)
United Association of Journeymen & Apprentices of the Plumbing and Pipefitting Industry
United Automobile, Aerospace & Agricultural Implement Workers of America International Union
United Cerebral Palsy Associations
United Furniture Workers of America
United Presbyterian Church
United States Catholic Conference
United Steelworkers of America
University of the District of Columbia/Institute of Gerontology
Washington Armed Services Committee
Washington State Labor Council, AFL-CIO
Waukesha County (WI) Central Labor Council
West Virginia Developmental Disability Planning Council
Western Gerontological Society
Westside Community for Independent Living
Wisconsin Council on Developmental Disabilities
Women's Equity Action League

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. HUTTON. I am William R. Hutton, the director of the National Council of Senior Citizens. I would appreciate it if my whole testimony was entered into the record. And I will deal with some high points.

There seems to be widespread agreement that the openended, retrospective, institutionally biased reimbursement model which is prevalent throughout the health care system is the major force driving up the cost of health care. Retrospective reimbursement, the basis of medicare payment, drives up the cost of the medicare program. But these rising costs actually represent a problem within a problem.

Congress has got to recognize that many of the problems in medicare are problems which prevail throughout the health care system. Therefore, to solve medicare's financial difficulties effectively, Congress must also address the larger health system problems.

Medical inflation continues to outpace that of the general economy. Attempts by the Reagan administration to modify that trend have failed. They have been off target, and designed only to reduce Federal spending. The President's fiscal 1984 proposals continue this strategy.

Some examples: In spite of unprecedented hospital inflation rates, and the fact that beneficiaries' current out-of-pocket expenditures as a proportion of income nearly equal those of pre-medicare levels, the administration would require the elderly to pay far more for hospital care. A 10-day hospital stay, which now costs $304, would cost the elderly patient $630 next year. That is more than 1½ times greater than the average monthly social security benefit.

Physician reimbursement levels would be frozen at current levels. The problem of physicians refusing to take medicare assignment, and thus charging patients fees exceeding allowable levels, is related to the already inadequate medicare fee schedules. Such a proposal will exacerbate the problem and force the elderly to pay even more for physician care.

The part B deductible and premiums would increase. These steps would pass greater proportions of program costs on to the beneficiaries and further erode their financial access to care.

The National Council of Senior Citizens therefore views a prospective payment system covering all insurers and all providers as an essential element of a systemwide cost control policy.

Our major concern is the anticipated impact that the diagnostic related grouping system will have on the medicare beneficiaries. Some of these concerns:

One, medicare admissions could be discouraged, thus denying access to older patients. Such discrimination could be subtle, but effective. For example, medicare patients in need of nonemergency elective procedures could be placed on waiting lists while patients with private insurance coverage are readily admitted. A similar practice might be employed to admit those elderly whose cases do not appear complicated or who might be more profitable over those who do. Some admissions could be encouraged whether or not the hospital is the most appropriate site for treatment. In another case, the use of ancillary services could be restricted, reducing the hospital's cost per case, but denying patients the services which adequately promote or enhance recovery.

Conversely, the use of ancillary contracted services which could be shifted out of DRG payment schemes and into part B reimbursement could be encouraged. The quality of care administered could be seriously impaired. For example, a hospital may opt for reducing its costs by cutting back on the staff qualifications and training. Patient-to-staff ratios, including professional and nonprofessional levels, could be changed.

The National Council sees many potential problems with the medicare-only, hospital-only prospective payment system, and these are included in the written statement which I have submitted for the record. I urge you to consider these questions which I have posed in that statement.

Mr. Chairman, NCSC believes that in spite of the urgent, widely recognized need for reimbursement reform, the DRG plan should not be rushed through the congressional processes. It is true that we cannot afford to let hospital inflation continue. However, we cannot afford to impose hastily a national, largely untested plan that will affect the operation of this Nation's hospitals and the health of its vulnerable citizens.

We believe that the social security compromise package now being considered by the Congress is also not the vehicle for considering a major reform of medicare reimbursement. It has been reported in the press there is some interest in attaching the DRG proposal to this compromise. Such a move would be inappropriate for several reasons.

It would threaten congressional approval of this delicately balanced compromise, it would interfere with the study of medicare in progress by the 1982 Social Security Advisory Council, due to report in July 1983; and it would allow virtually no time for the Congress to study adequately the plan, the current administration plan, or to study Congressman Ron Wyden's alternative, H.R. 1227, and to have public input to make an informed decision.

Let me emphasize that DRG's can be acceptable if they are modified to eliminate some of the problems and concerns voiced here today. Please keep in mind, however, that any medicare reimbursement reform which will be ineffective on the whole health care system and a wasted effort unless it is soon followed by a systemwide plan to reduce health care costs for everyone, and not just the Federal Government.

Thank you, Mr. Chairman.

Chairman JACOBS. Thank you.

[The prepared statement follows:]

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman, members of the Committee, I am William R. Hutton, Executive Director of the National Council of Senior Citizens. The National Council is a membership organization which represents over four and one-half million older persons through 4,500 clubs and councils in every state. The majority of our members are Medicare beneficiaries who will be affected by the changes in Medicare reimbursement which this committee is considering. We appreciate the opportunity to share with you our views on Medicare prospective payment to hospitals.

The National Council of Senior Citizens was founded twenty years ago during the fight for enactment of a national health plan for the elderly—Medicare. Since that time, NCSC has been in the forefront of efforts to improve and preserve Medicare as well as to assure that our country's health care delivery and financing systems adequately serve people of all ages.

Mr. Chairman, the National Council of Senior Citizens has appeared before this subcommittee on numerous occasions to discuss Medicare from the beneficiary's perspective. During the past two years in particular, in an environment of severe Federal budgetary constraint, our message to you has been: the elderly have extraordinary health care needs and expenses of which the Medicare program covers only a portion. Whatever program or policy changes you recommend or adopt, we urge you to consider the shortcomings of Medicare for the beneficiaries and any impacts these changes may have on them. Today I underscore this message.

This panel is addressing one of the most serious problems in our health care system and the Medicare program: the cost of hospital care. While there seems to be increasing agreement about the major causes and effects of rising hospital costs, there has been less agreement on what will solve the problem. Therefore, no effective system-wide cost savings plan has been adopted to date. In addition, Medicare-only reductions have not helped but have just shifted costs rather than lowering them. What effect the reimbursement limits enacted through the Tax Equity and Fiscal Responsibility Act (TEFRA) will have on hospital costs has not yet been demonstrated in the short time these limits have been in place.

There seems to be widespread agreement that the open-ended, retrospective, institutionally biased reimbursement model prevalent throughout the health care system is the major force driving up the cost of health care. This system encourages spending on the more expensive services such as hospital and other institutional care while leaving gaps in coverage of other less costly but necessary services. The system, moreover, rewards provider spending and inefficiency rather than cost-consciousness and efficiency.

Needless to say, this reimbursement arrangment has produced problems which seriously affect all participants in the health care system as well as elements outside of the system. The problem that the Committee must address is how this reimbursement affects Medicare and what Congress should do about it.

Retrospective reimbursement, the basis of Medicare payment, drives up the cost of the Medicare program, but these rising costs actually represent a problem within a problem. Congress must recognize that many of the problems in Medicare are problems which prevail throughout the health care system. Therefore, to effectively solve Medicare's financial difficulties, Congress must also address the larger health system problems. To do so requires an understanding of the dynamics within and outside of Medicare.

Some of the elements straining Medicare financing and benefit adequacy are:

Highly inflated hospital costs are pushing up Medicare program costs. While the CPI for 1982 was 3.9 percent, hospital inflation was 12.6 percent. Over the past three years, hospital inflation has caused Part A expenditures to increase an average 19 percent each year.

The disproportionate Medicare spending on hospital care, which accounts for nearly 75 percent of Medicare expenditures, consumes resources which should be available for non-hospital care.

Rising Medicare program and overall health care costs are steadily eroding the adequacy of Medicare benefits and preclude payment for needed services not currently covered. Consequently, beneficiaries incur increasingly larger out-of-pocket expenditures.

The size of the Medicare budget has made the program a target of the Administration's budget/deficit reducing strategies. These strategies have simply decreased the federal commitment and disregarded such vital elements as current benefit inadequacy, real causes of cost increases, and the growing financial burden on the beneficiary.

Medicare's problems do not exist in isolation. Many of them reflect problems in the larger health system. Some of the elements which prevail in that system are:

National health care spending has been steadily rising in the last two decades to a point where it now accounts for 10 percent of the GNP. Much of the recent increase is attributed to unprecedented medical inflation rates.

Health care expenditures affect the national economy. Rising health care costs increase the cost of other goods and services. For example, the rising cost of insuring against health care expenses affects not only individuals, but also the price of labor.

Employers must pay higher premiums for workers' health insurance. They in turn pass their increased expenses onto the consumers of the goods and services they sell.

An increasingly larger proportion of national resources is devoted to health care at the expense of other goods and services.

The consequent problem in an inflation plagued industry such as health care becomes not necessarily the proportion of dollars spent, but how well the money is spent. Therefore, we must ask: Is the increasing amount of GNP spent on medical care buying a comparable amount of improved care, or are we just spending more for the same product?

Rising health care and related costs encourage inappropriate and frequently counter productive responses to save money. These range from individuals' avoidance of necessary care due to the cost and reductions in employer paid health insurance coverage.

Both sets of problems, those of Medicare and those of the larger health system, must be solved. A strategy, however successful, applied just to the Medicare program will solve neither set. It could affect Medicare by netting some short-term budgetary savings, but the problem of rising costs will not disappear. It will resurface elsewhere in the system, and health care costs will continue to escalate.

Evidence abounds to substantiate the need for deliberate, system-wide reform to control Medicare and other health care expenditures. Medical inflation continues to outpace that of the general economy. Attempts by the Reagan Administration to modify that trend have failed. They have been off-target and designed only to reduce federal spending. What they have accomplished, however, is the imposition of unreasonable financial burdens on the elderly and the encouragement of providers to continue their cost increasing and cost shifting behaviors.

The President's fiscal year 1984 proposals continue this failed strategy to a shocking degree. Never before have effects on the elderly of both the Administration's misguided budget policies and the uncontrolled hospital inflation have been more apparent. Hospital costs are rising but the fiscal year 1984 budget would impose copayments on the beneficiary. These proposals demonstrate that the need for reimbursement reform is greater now than ever before. These are some examples of the Medicare proposals:

In spite of unprecedented hospital inflation rates, and the fact that beneficiaries; current out-of-pocket expenditures as a proportion of income nearly equal those of pre-Medicare levels, the Administration would require the elderly to pay far more for hospital care. A ten-day hospital stay which now cost $304 would cost the elderly patient $630 next year. That is more than one and a half times greater than the average monthly Social Security benefit!

Physician reimbursement levels would be frozen at current levels. The problem of physicians refusing to take Medicare assignment and thus charging patients fees exceeding allowable levels is related to the already inadequate Medicare fee schedules. Such a proposal will exacerbate the problem and force the elderly to pay even more for physician care.

The Part B deductible and premiums would increase. These steps would pass greater proportions of program costs onto the beneficiaries and further erode their financial access to care.

These proposals would not generate true cost savings but cost shifting. They and others such as vouchers, delayed eligibility, and the prospect of catastrophic coverage are thinly veiled attempts to reduce Federal responsibility and commitments regardless of the disproportionate burdens such steps will place on the elderly and the private sector health consumers, insurors, and providers. Such unconscionable recommendations clearly illustrate how urgent the need is for health system cost savings strategies.

What strategies would produce the savings which are so desperately needed but which have thus far eluded us? One promising plan is to implement a prospective payment system. The National Council of Senior Citizens has long advocated such a system as an effective means of cost control because it encourages cost consciousness and economic efficiency among health care providers and places the providers, not the patients, at risk. Until providers become financially accountable for their decisions, we believe that this country will not begin to control health care costs.

The National Council of Senior Citizens, therefore, views a prospective payment system covering all insurors and all providers as an essential element of a system-wide cost control policy. We believe that prospective payment should be applied toward the entire health care system.The resultant savings would benefit all purchasers of health care, including the Federal government and the Medicare beneficiaries.

Until a system-wide prospective plan is adopted, we believe that the Administration's recommendation of a Medicare prospective payment plan for hospitals could be a step in the right direction. However, since such a plan could merely shift more of the government's cost to other purchasers of hospital services and yield no system-wide savings or efficiency, we caution you to consider this plan very thoroughly.

Our major concern is the anticipated impact that the Diagnostic Related Groupings System (DRG) will have on the Medicare beneficiary. I will now discuss some of these concerns.

In theory the DRG plan has many attractions. It would reimburse hospitals according to complexity of cases rather than the length of hospitalization and intensity of services used by each patient. Thus it would attempt to streamline hospitals' costs by offering monetary incentives for limiting resource use to only that which is appropriate and necessary for each DRG. The standard cost would be a pre-determined rate for each diagnostic related grouping.

We believe that the immediate beneficiary of a DRG plan would be the Federal government. Ultimately the older person would benefit because the government should be able to better use its limited Medicare resources. However, we also believe that there is a danger that the government would be the only beneficiary of the savings. If that should happen, or if the wrong provider incentives are encouraged by DRGs, the elderly Medicare beneficiary will be harmed, whether or not additional cost-sharing is prohibited.

During your deliberations you undoubtedly will hear of the ways that DRGs are expected to save Medicare dollars, to promote hospital efficiency, and to allow for predictability of expenditures. These are desirable goals and we urge you to adopt a system that will achieve them. However, we also urge you never to lose touch with one element that can be lost as DRG advocates try to impress you with terms like "ease of administration", "quick implementation", "predictable payment", "prudent buyer", and "reduced administrative burden". The element that cannot be omitted is the "patient."

I will now cite some possible situations in which NCSC believes the beneficiary could be harmed under a DRG system if hospitals do not respond as the Administration predicts:

Medicare admissions could be discouraged, thus denying access to older patients. Such discrimination could be subtle but effective. For example, Medicare patients in need of non-emergency or elective procedures could be placed on waiting lists while patients with private insurance coverage are readily admitted. A similar practice might be employed to admit those elderly whose cases do not appear complicated (or who might be more "profitable") over those who do.

Some admissions could be encouraged whether or not the hospital is the most appropriate site for treatment. Older people are at very high risk of complications when hospitalized. If a hospital deems it more profitable to admit certain cases now treated on an out-patient basis, the Medicare patient will be exposed unnecessarily to further illness. In addition Medicare costs will increase.

The use of ancillary services could be restricted, reducing the hospital's cost per case but denying patients the services which adequately promote or enhance recovery. The amount of physical therapy administered, for example, could determine the functional level of an older person at discharge and the need for post-hospital care.

Conversely the use of ancillary contracted services which could be shifted out of DRG payment schemes and into Part B reimbursement could be encouraged. HHS may prohibit paying twice for a service (under A and B), but charging under Part B will increase the patient's financial responsibility because of the co-payment requirement and the assignment problem.

The quality of care administered could be seriously impaired. For example, a hospital may opt for reducing its costs by cutting back on staff qualifications and training, patient to staff ratios (including professional and non-professional levels), purchase of new technology, and upkeep of equipment, to cite just a few undesirable cost-cutting techniques. The Administration's recent move to relax regulations governing hospitals participating in Medicare could exacerbate the problem.

The length of hospital stay could be inappropriately shortened, seriously affecting the Medicare patient's discharge status. For example, for many older people, one or two days added to or cut out of a hospital stay could mean the difference between going to a nursing home after discharge or going to one's own home. Cutting a hospital stay too short may save the hospital money but, when shortened inappropriately, it can add to Medicare's after hospital costs and threaten the patient's recovery.

Can these situations occur? We believe they can, although we feel that most hospitals will strive to avoid such practices. However, some may do so unwittingly if reimbursement levels are too low or arbitrarily applied to DRGs. Others, motivated more by profit than by dedication to good patient care, may do so deliberately. We hope such practices do not occur, but we are not convinced that the necessary safeguards will exist to either monitor or discourage such behavior.

The National Council of Senior Citizens sees many other potential problems with a Medicare only, hospital only prospective payment system. To illustrate these problems, I will pose a series of questions. (The assumption I am making is that such a system will be based on the HHS, DRG model, but most of these questions should be asked of any prospective system.)

Can a prospective payment system be applied only to Medicare without causing "savings" to become costs for other insurors as well as the whole health care system?

If the system does not produce the predicted Federal savings and provider efficiency, will the beneficiary be taxed with additional cost-sharing to compensate for its failure?

Can the elderly patient with multiple diagnoses, chronic illness, and debility fit neatly into a DRG category? How will complications which occur after admission be considered under the DRG scheme? Will the DRG adequately compensate the hospital for these problems?

Will hospitals or physicians manipulate diagnoses or patient descriptors to slip a case into a similar category with a higher reimbursement level? (DRG creep)

Will the reimbursement levels reflect true per case costs or merely the government's desired spending targets? Will the "prospective" part of DRGs just apply to the Federal government's benefit? That is, will the government set its budget and then set DRG rates to fit that budget?

How will hospital administrators, trying to cut costs per case, affect physicians' admissions practices and utilization of hospital services? Will the physician have any incentive to reduce hospital costs? Will the physician gain if he/she helps to reduce costs per case?

Will physicians treat more cases in their offices, at greater expense to the beneficiary (since reimbursement for physician care requires a patient co-payment) and at possible risk to the patient where out-of-hospital care is inappropriate?

How will hospitals with currently high Medicare and Medicaid populations or legitimately high special costs be able to operate under the DRG prospective system? Will some have to close, cutting off access to the beneficiary? (Particularly vulnerable are the inner city and rural hospitals.)

Since the plan will squeeze only Medicare reimbursement, what costs will be shifted to other insurors and non-Medicare patients to compensate for the limitation of Medicare reimbursement?

Can we expect a parallel effort by private insurors to institute prospective reimbursement to avoid cost shifting without firm federal commitment to encourage such a response?

Will hospitals be reimbursed for uncompensated care? Or will such costs be shifted to non-Medicare payors?

Will states be allowed flexibility to operate current or developing state cost-control plans?

Will health maintenance organizations, proven systems of efficiency and cost-savings, be treated separately to prevent their costs from increasing as they have under the New Jersey plan?

The basic concept of prospective payment is a good one, and such a plan could be successful if these problems are addressed. However, at a time when reimbursement reform is needed to make the whole health system economically efficient, DRGs should be considered only a first step. It is a step that needs to be taken but one that Congress should not implement without improving the plan and looking toward applying reimbursement reform systemwide.

The National Council of Senior Citizens believes that to solve some of the problems I have mentioned, flexibility should be built into the DRG system's design and implementation. In addition, steps should be taken to further assure beneficiary protections.

We believe that to mandate a prospective payment plan based on only one, nationally applied model, such as would be required by the Administration's proposal, would penalize many states and preclude the flexibility they need to achieve effective cost containment. For example, during the past several years, mandatory hospital cost containment programs have been adopted in Connecticut, Maryland, Massachusetts, New Jersey, New York, Rhode Island, Washington, and Wisconsin. All of these states provide convincing evidence that prospective budgeting and payment lead to savings in total hospital costs and in cost per admission compared to the present cost reimbursement method. These programs have similar goals but an essential element is different: Each state's program is tailored to meet the needs of that state.

A mandated national DRG plan would preclude maintaining a program that has worked successfully for a state and which, in many cases, is applied to all payors. In some cases it would require that a uniform program be modified for one payor: Medicare.

NCSC believes that implementation of a prospective payment system which allows the states some flexibility without compromising DRG's goal is possible. Perhaps the DRG plan could be used as a baseline model. As long as a state's plan generates savings equal to or greater than those anticipated from DRGs, the state plan should be allowed to continue. Thus the goals of economic efficiency and predictable budgets would be preserved.

The National Council of Senior Citizens is particularly concerned about treatment of the Medicare beneficiary under a DRG plan. The Department of HHS has responded to fears of system abuse, DRG creep, and handling of outliers by promising monitoring of admissions, verification of DRGs, and adjustments in payments. Such steps are necessary and could be effective in certain cases, given adequate HCFA staffing and effective state monitoring activities. However, we are also concerned about the problems which may never be exposed to such monitoring. For example, a beneficiary who experiences subtle discrimination by a hospital, perhaps through a queuing technique, or a beneficiary who receives inappropriate out-of-hospital care will not be considered by a utilization review committee or a monitoring of hospital admissions. Yet these beneficiaries could be harmed as much as those who suffer as a result of DRG system abuse, for example unnecessary surgery.

Mr. Chairman, the NCSC believes that in spite of the urgent, widely recognized need for reimbursement reform, the DRG plan should not be rushed through the Congressional process. It requires very careful examination of how the plan will affect all involved groups, consideration of alternative measures, and determination of what the plan will actually accomplish.

We urge you to devote adequate time to take these necessary steps. It is true that we cannot afford to let hospital inflation continue. However, we also cannot afford to hastily impose a national, largely untested plan that will affect the operation of this nation's hospitals and the health of its vulnerable citizens. Quick implementation can lead to long-term damage that could be harder to reverse than it would be to solve the current problems.

We believe that the DRG plan must be considered not only thoroughly, but also separately. To rush it through as part of the fiscal year 1984 budget would preclude the scrutiny it requires, and could lead to its failure. The budget process, therefore, is not the proper vehicle for this plan. We understand that the Reagan administration would like to see DRGs in place by October 1, 1983. However, such hasty implementation could only result in ill-advised short-term budgetary savings at the expense of some hospitals and their Medicare patients.

We believe that the Social Security compromise package now being considered by the Congress is also not the vehicle for considering a major reform of Medicare reimbursement. It has been reported that there is some interest in attaching the DRG proposal to this compromise. Such a move would be inappropriate for several reasons: It would threaten Congressional approval of this delicately balanced compromise; it would interfere with the study of Medicare in progress by the 1982 Social Security Advisory Council due to report in July, 1983; and it would allow virtually no time for the Congress to adequately study the plan, hear public input, and make an informed decision.

Let me emphasize that a DRG prospective payment for Medicare must be considered as a part of a health system-wide plan for cost containment which includes all payors and all providers. As a first step in such a plan, DRGs can be acceptable if they are modified to eliminate some of the problems and concerns voiced here today. Please keep in mind however that any Medicare reimbursement reform will be ineffective on the whole health care system, and a wasted effort unless it is soon followed by a system-wide plan to reduce health care costs for everyone, not just the Federal government.

In closing, let me ask one final, critical question: What is the alternative to prospective payment under Medicare? Further hospital inflation? Further cost-sharing by the beneficiary? A voucher system? A means test? Reduction of Medicare benefits? The answer is simple: These are not reasonable alternatives. A suitable cost-saving system which includes prospective payment must be designed and implemented.

STATEMENT OF JAMES M. HACKING, ASSISTANT LEGISLATIVE COUNSEL, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. HACKING. My name is James Hacking. I am assistant legislative counsel for AARP, which has membership now in excess of 14 million persons age 55 and older. Since the association's statement is to be included in the record of this hearing, I shall keep my remarks as brief as possible.

Health care costs in general and hospitals' costs in particular have continued to escalate at unacceptably high, double-digit rates despite the sharp decline in inflation in all other sectors of the economy. While the consumer price index increased only 3.9 percent last year, hospital costs increased nearly 14 percent. Since 74 percent of all medicare expenditures are for hospital care, rapidly rising hospital costs have resulted in rapidly rising medicare program costs to the point where the HI trust fund faces imminent insolvency.

The essential prerequisite to addressing the near term HI trust fund financing problem is a stabilization of hospital costs. AARP believes that a properly designed prospective payment system can greatly help to stabilize the growth of hospital costs by introducing the proper incentives for hospitals to control those costs.

The following specifications outline the basic criteria AARP considers important in developing a prospective payment plan. These specifications reflect AARP's continuing commitment to effective health care cost containment and the quality of care. Moreover, we believe these specifications address critical financing problems for inner city and teaching hospitals and they allow States the flexibility to achieve health care sector savings under their own prospective payment plans.

First, with respect to coverage, the prospective payment system should cover all payors, all services and all hospitals. Otherwise there will be cost shifting, or cost shifting through patient shifting. Exemptions from coverage should be allowed only when coverage results in higher costs to the system.

Second, in our view the basis of payment that offers the best chance for developing a meaningful pricing mechanism is HHS selection: Diagnostic related groups. It is essential, however, that the payment formula include a severity of illness index and provisions for teaching hospitals, uncompensated care and capital funding. Also, DRG rates should be reviewed periodically and adjusted according to a preestablished formula.

Third, on the issue of assignment, we think assignment should be mandatory for hospitals and physicians employed by or contracting with hospitals.

Fourth, AARP believes there must be a strong utilization review capability as part of any prospective payment system—one that includes adequate consumer representation and enforcement powers.

Fifth, with respect to the issue of Federal preemption, we believe States should not be forced into a single prospective payment plan; within broad guidelines specified by HHS, States should be permitted to develop alternative plans as long as the savings projected are equal to or greater than the savings expected under the Federal plan.

Finally, AARP believes that prospective payment legislation should not be put on a fast legislative track, or developed as part of the fiscal year 1984 budget process. A complete overall of the mechanism by which the Federal Government will spend nearly $45 billion in fiscal year 1984 for health care services deserves careful and deliberate consideration.

Prospective payment legislation should not be rushed through to enactment. It might end up doing more harm than good.

That completes my remarks, Mr. Chairman. I thank you for having had this opportunity to present them.

Chairman JACOBS. Thank you.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS

INTRODUCTION

The American Association of Retired Persons is pleased to state for this subcommittee its view of the prospective payment concept in general and the diagnostic related groupings (DRG) methodology in particular. AARP has long supported and urged Congress to design and implement a prospective payment methodology to control health care costs. We welcome the development of this dynamic reimbursement concept as an essential step toward stabilizing hospital costs.

CONTEXT OF THE PROBLEM

Health care costs in general hospital costs in particular have continued to escalate at unacceptable rates despite the sharp decline in inflation in all other sectors of the economy. Thus, though the Consumer Price Index for 1982, increased at an annual rate of 3.9 percent, hospital costs soared at nearly 14 percent.

The result of runaway inflation in the health sector of the economy has been runaway inflation in the Medicare Program. Medicare expenditures have increased by an average of 18 percent per year for the last five years. Since 75 percent of all Medicare expenditures are for hospital care, soaring hospital costs mean there will be no relief in Medicare expenditures soon.

The growth in Medicare expenditures has had a profound impact on the Hospital Insurance (HI) Trust Fund. Recent legislative changes bringing federal employees into the Medicare Program have given the HI Trust Fund a few additional years of solvency. Nevertheless, HCFA projects the fund will not have enough funds on hand to meet its obligations by some time this decade. And unlike the Old Age and Survivors Trust Fund, the deterioration in the HI Trust Fund will not be reversed by the more favorable economic and demographic conditions expected to prevail in the 1990's. Congress and the American people are facing the erosion of the nation's commitment to health care for the elderly and disabled. Coming to grips with that reality and sustaining the commitment to accessible, affordable health care for the aged and disabled is the explosive dilemma resulting from uncontrolled hospital inflation.

The essential prerequisite to addressing the near term Hospital Insurance Trust Fund financing problem is the stabilization of hospital costs. Without stable hospital costs nothing is possible: Medicare and Medicaid expenditures will continue to escalate beyond reason; employers will pay higher and higher health insurance premiums which further lessen their ability to employ new workers because of rapidly increasing payroll taxes; the HI Trust Fund will continue to deteriorate, and all health care consumers, including the elderly, will pay higher out-of-pocket costs for health care.

THE PROSPECTIVE PAYMENT CONCEPT

The American Association of Retired Persons believes that prospective payment can help stabilize the uncontrolled growth in hospital costs. Prospective payment (PP) introduces three new incentives for hospitals to control costs: (1) hospitals are motivated to anticipate and justify future expenditures and to establish the need for new facilities and services in attempting to gain recognition of the costs of their plans in their prospective rates; (2) hospitals are motivated to identify and monitor the cost implications of the quantity, quality and scope of services they provide to operate within their rates; and (3) hospitals are motivated to keep their actual costs below their rates to avoid losses and achieve surpluses. This could lead to more effective and efficient operations.

AARP believes that a hospital, by containing its costs, can earn a surplus sufficient to maintain its viability while receiving less revenue than it otherwise would receive under current reimbursement methods. This belief, central to the PP concept, is the basis for our support and optimism about the efficacy of prospective payment.

ESSENTIAL ELEMENTS OF A PROSPECTIVE PAYMENT PLAN

There are over thirty prospective payment plans in operation around the country; some are run by State agencies, Blue Cross plans, some by hospital associations and some by private insurers. Though important substantive differences occur as a result of how a plan establishes the amount of its prospective payment (i.e., by rate commission, mathematical formula, face to face negotiation, etc.), the extent to which hospitals, services and payors are covered by the plan as well as the basis of payment (i.e., per discharge, per diem, per diagnostic related group (DRG) are, in general, more important indicators of a plan's chances to control spiraling health care costs, than are the structure and methods of the cost controlling administration.

A. Coverage

Coverage describes the extent to which major elements of the health care delivery system are under the jurisdiction of the prospective payment system. Generally speaking, the greater the coverage the greater the chances that the system can control costs. HCFA sponsored research shows that the extent to which a prospective reimbursement system covers *payors* (Medicare, Medicaid, Blue Cross/Blue Shield, private insurers, etc.) services (Part A/Part B inpatient/outpatient), and hospitals (any exemptions from coverage) will, usually to a like extent, determine the ability of the prospective system to control cost.

(1) Payors.—The more payors covered by a prospective payment program, the lower the ability of the hospital to circumvent revenue controls for some payors by raising prices charged to other, noncovered payors.

Congress' mandate to HHS is to develop legislative proposals which provide that hospitals, skilled nursing facilities (SNF) and, to the extent feasible, other providers would be paid under Medicare on a prospective basis.

This mandate is insufficient because it limits the prospective payment system to Medicare. A Medicare specific payment system makes it very difficult, if not impossible, to control health care inflation because of cost shifting.

The process by which hospitals cover discounts given certain types of payors, such as Medicare and the Blues, by assessing those discounts against other payors, usually private insurance companies, is called cost shifting. According to the Health Insurance Association of America (HIAA), 16 percent of the hospital expenses paid by private insurance is for discounts taken by Medicare and Medicaid patients. Cost shifting has increased so much that health insurance premium payors can no longer absorb the increase in premium rates necessary to finance the shift. All three categories of witnesses (HIAA, Blues and GHAA), at a recent Senate Health Subcommittee hearing on Medicare reimbursement, agreed that Congress must create a "level playing field" so that all payors for health care services are treated fairly. As long as hospitals can continue to shift costs, they will have no incentive to be more efficient.

(2) Services.—Though the Congressional mandate speaks to "hospitals, SNFs and, to the extent feasible, other providers," it is important that all services—Medicare Parts A and B, inpatient and outpatient services—be covered under the prospective payment plan. In the absence of such coverage, there is the real possibility that a change of services from Part A to Part B or from inpatient to outpatient will result in additional payments without any reduction in payments under Part A.

For example, if a hospital leases its radiology department to a physician, that service will stop being Part A and become a Part B service. Under a prospective payment system, the hospital would receive the prospective payment for the inpatient services. In addition, however, the now Part B x-rays will cost the system an amount in excess of the prospective limit, thus undercutting the purpose and savings of the prospective payment plan. Similarly, if outpatient services are not covered under the prospective payment plan, hospitals could collect the prospective payment for inpatient services and then transfer the patient to outpatient status where additional revenues could be exacted.

(3) Hospitals.—Any exemption for hospitals from the prospective payment system msut be carefully considered, especially within the context of the proposed plan because of the potential for cost shifting through patient shifting. Cost shifting through patient shifting occurs when some hospitals within a local hospital market are exempted from participation in the prospective payment program, but others are not.

For example, under the first AHA plan, small hospitals (100 beds or less) had the option of participating under the plan or not. Because the first AHA prospective payment methodology provides for discharge-based payments, determined by inflating full historical costs per discharge, a small hospital opting into the prospective system would receive full inflated costs for every discharge in the budget year. If these discharges were drawn from a neighboring small hospital (same number of beds) which opted to remain on cost-based reimbursement, the latter hospital would lose no revenue unless they reflected their volume reduction in lower costs. The potential for cost shifting through patient shifting makes it important to require that participation options be uniformly exercised within local hospital markets.

B. Basis of payment

The basis on which a prospective payment plan establishes the amount of payment has an important influence on the incentives created by the program. For example, programs that limit the total revenues of a hospital, rather than establish per diem or per case rates, create less incentive for hospitals to circumvent the system by increasing admissions and length of stay. Programs limiting total revenues, however, must closely monitor hospital revenues for compliance. The looser the monitoring, the longer the lag between receipts and compliance, the more difficult it is to control hospital costs. Programs that set payment rates, on the other hand, affect a hospital's cash flow immediately and, therefore, affect costs immediately.

There are a number of methods by which to determine the basis of payment in a prospective payment system. The simplest methods to administer, establishing the payment on a per admission, per diem or per discharge basis, create strong incentives to either increase hospital admissions, extend hospital stays or skim the healthy patients who are less expensive to treat while avoiding the more costly ones.

A variation of the per admission method that reduces incentives to skim healthy patients adjusts the payment per admission for differences in overall patient case mix. The Department of Health and Human Services (DHHS) favors a case mix approach—diagnostic related groups (DRGs)—for determining the basis of payment in the HCFA prospective payment plan.

In the Department's DRG system, patients are grouped by major diagnostic categories. These are further divided by five variables that explain, with an acceptable degree of accuracy, variations in resource consumption as measured by length of stay for different illnesses. This procedure results in 467 diagnostic related groups (DRGs).

The hospital is paid on a per case basis with the amount of payment based on rates calculated for each DRG. If a hospital spends more than its DRG rate for a specific diagnosis, it loses money. If it is able to treat the patient for less, the hospital keeps the savings.

DRGs offer several important advantages. In addition to neutralizing perverse incentives inherent in other prospective payment methods, the number of DRGs is manageable, the groups are medically related and statistically similar, and the information required to administer the system provides a significant management tool.

DRGs do, however, have problems, too. Perhaps the most troublesome problem from a cost savings point of view is DRG creep. DRG creep occurs when providers "game" the system by fudging a diagnosis in order to get a patient into a higher paying DRG category. Similarly, DRGs could encourage unnecessary surgery because payment for the same diagnosis is higher when surgery is involved. The elderly already have surgery at a higher rate (165 surgeries/1000 population) than the under age 65 population (92 surgeries/1000 population). Hence, it is essential that any prospective payment system have a strong utilization review program to address these problems.

DRG critics also object to tying diagnoses to payment rates because it could interfere with the development of new, more effective technologies. Methods of evaluating innovations could be developed, however, so that new technologies could be incorporated into the DRG payment system. However, interference with the automatic implementation of new technology could be considered a benefit of the DRG system.

New technology is a powerful force driving up hospital costs. Though health planning and the certificate of need process has forced significant savings by disapproving unnecessary purchases of new technologies, the health care system has yet to develop an adequate method of evaluating the cost of new technology relative to its benefits. The systematic evaluation of new technology to be incorporated into the DRG payment system could be an effective method of relating benefits (of innovation) to costs. Such systematic scrutiny of new technology could contribute to the quality of care and the ultimate cost of care.

DRGs appear to present a particular problem for health maintenance organizations (HMOs). Some argue that per case reimbursement, based on average length of stay, neutralizes and even reverses the traditional HMO incentive to reduce length of stay. Why should HMOs encourage hospital stays below the average for a specific diagnosis if the HMO must pay on the basis of the average? Development of the DRG based prospective payment system must not be permitted to undermine the savings potential of HMOs. The Department's solution, offering HMOs the option of being paid on a per capita basis, as current law allows, or receiving the same DRG based prospective rates as hospitals, seems adequate under current circumstances; HMOs have a small market share and the prospective proposal is Medicare specific. Nevertheless, HMOs in the DRG system should continue to be studied and monitored so that one cost containing system does not disadvantage another.

The most decisive determinant of the efficacy of DRG reimbursement is the payment formula. DRGs are intended to be length of stay homogeneous groups which take into account five variables: the patient's age, the presence or absence of a secondary diagnosis and the presence or absence of surgery. Relying on length of stay, the patient's age and the other variables, however, does not produce a sufficiently sensitive surrogate for resource consumption to differentiate patients' burdens of illness.

A fundamental requirement for control of inpatient hospital costs is a means of classifying patients by a standard that accurately reflects a patient's use of health care resources. AARP believes that the DRG payment formula must take into account severity of illness to effectively match reimbursements to patient mix. Otherwise, urban public hospitals, those hospitals with the sickest patients and most expensive mix of cases, will not be adequately compensated under a DRG based system.

AARP supports DHHS' decision to base the DRG payment formula on national averages, adjusted for wage levels in various parts of the country. We believe that tying the DRG payment formula too closely to local norms may perpetuate utilization patterns in much the same way that PSRO norms did for length of stay. HCFA has reported to Congress wide variations in hospital utilization among regions of the country. In the Northeast, for example, in 1979, total days of hospital care per thousand for Medicare patients was 4,124 days. In contrast, the West had only 2,752 days. These differences are not accounted for by age, sex, race or case-mix standardization. They are historically consistent and apply to the under 65 population as well.

Some believe that the large number of HMOs in the West account for part of the difference. Most believe, however, that the variance is caused by physician practice patterns—a complex set of beliefs, attitudes and practices—common to the region. If doctors on the East coast discharged patients like doctors on the West coast, Medicare would save an estimated $10 billion a year. Differing physician practices, having no basis in medical necessity, are detrimental to Medicare and Medicare beneficiaries. By making physician practice norms roughly uniform for all regions, it puts hospitals and physicians at risk for the services they provide.

AARP believes that DHHS's proposal to leave future rate adjustments solely to the discretion of the Secretary will unnecessarily politicize the Medicare payment mechanism. ARRP supports a fixed DRG rate review schedule and a specific formula for adjusting the rates from time to time. The formula should consider evaluations of past performance for each DRG, as well as evaluations of future developments impacting DRG rates. Furthermore, the views and comments of representatives of Medicare recipients must be solicited and considered in the process of adjusting DRG rates; with a thirty day review and approval procedure for proposed rates afforded the appropriate committees of the Congress.

Three additional areas traditionally dependent upon the reimbursement mechanism for financing must be considered, directly or indirectly, in the new payment scheme. Whether or not the three areas—allowances for teaching hospitals, uncompensated care and capital funds—should be financed through the third party reimbursement system is a policy question that deserves wide-ranging debate. The Department has chosen to exclude capital and medical education costs from the DRG rate calculation and reimburse for them separately. AARP recognizes the complexity of the issues involved and understands the desire to move the prospective payment systems as quickly as possible without additional complications. Nevertheless, the importance of capital and medical education costs to the health care system can no longer be ignored. AARP urges Congress to initiate a full, fair and wide-ranging debate on these issues at the earliest possible time. The most appropriate financing mechanism for medical education, uncompensated care and capital will probably be different for each activity. These activities are fundamental, however, to our health care system; how they are financed will have a major influence on who gets care and how and where it is delivered. Serious consideration of these issues can no longer be postponed.

Finally, DRGs only apply to hospital inpatients. An outpatient DRG system must be developed if the system is to fully realize its potential for savings.

C. Assignment

Under current law, assignment (accepting what medicare pays as payment in full) is mandatory under Part A and optional, at the discretion of the physician on a case by case basis, under Part B. Moreover, many people wonder why Medicare contracts with hospitals that do not require hospital based physicians to accept universal assignment.

After a Medicare patient has surgery, the hospital bill goes to the Part A intermediary and the surgeon's bill goes to the Part B carrier. Under current law, there is no check on whether the surgery billed was actually performed or was as complex as indicated in the hospital record. Through the Association approaches the issue of universal assignment with an open mind, merging Part A and Part B services—at least in the inpatient context—seems to offer both financial and administrative advantages.

AARP is fully aware of the special interests advocating that hospitals be permitted to choose, like physicians, whether or not to accept assignment. Any Medicare hospital payment proposal that would permit hospitals to bill beneficiaries for any sum beyond the appropriate DRG rate would contribute to cost inflation and be unacceptable to AARP. Furthermore, any perspective payment plan that requires greater direct out-of-pocket expenditures for Medicare participants than does the current law is not acceptable to AARP.

D. Utilization review

HCFA studies show that programs imposing utilization penalties on hospitals are likely to curtail revenues more than programs that do not impose such controls. Utilization review is, therefore, an essential tool for controlling costs no matter what type of prospective reimbursement system finally emerges.

Whether the basis of payment is per diem, per discharge, or per DRGs, if left uncontrolled, health care providers will "game" the system in increase reimbursements. To minimize "gaming" and thereby more effectively control costs, the prospective payment plan must have a strong commitment to utilization review. An adequate utilization review mechanism would include beneficiary representation, full access to pertinent information, very narrow, if any limitations on disseminating information, and an effective enforcement capability.

AARP agrees with former Secretary Schweiker that utilization review is crucial for a successful prospective payment system. We question the Administration's commitment to DRG based prospective payment while totally phasing out PSROs. We urge Congress to provide adequate funding, consumer representation and meaningful enforcement capabilities so that Professional Review Orgainzations (PROs) can fill the necessary void created by the demise of PSROs.

E. Federal preemption

AARP has long supported a prospective reimbursement approach to contain hospital costs. Beyond that broad notion, however, the Association believes it is essential that states, within general guidelines, have the flexibility to implement the prospective payment concept as they see fit. Each state is unique. What works in New Jersey may not work in California. AARP opposes restricting states to a single prospective payment methodology.

Within broad guidelines and uniform reporting requirements specified by HHS, states should have the flexibility to develop their own prospective payment plan as long as the savings projected are equal to or greater than the savings under the federal plan.

F. Prospective reimbursement and the legislative process

Hospital reimbursement is the heart and lungs of the Medicare Program. Like heart and lung surgery, change in Medicare reimbursement is a complicated and delicate operation. Like heart and lung surgery, the stakes are the life or death of the national commitment to high quality, accessible, affordable health care for the elderly and disabled.

AARP believes that the seriousness and scope of this undertaking require the most deliberate legislative consideration. We urge Congress to proceed with the development of prospective payment separately from consideration of the fiscal year 1984 budget and certainly not in connection with any other "fast track" legislation. The harried and chaotic nature of the fast track, like the budget process, does not lend itself to the in-depth scrutiny and deliberation required to change the Medicare reimbursement system.

Moreover, though we recognize and are sympathetic to industry's desire for the stability prospective pricing promises, a complete overhaul of the mechanism by which the federal government will spend $44.7 billion in fiscal year 84 deserves careful and deliberate consideration. The recent extension of section 223 limits to ancillary hospital costs deserves a chance to become effective. Coupling prospective reimbursement legislation to the fiscal year 1984 budget would not allow sufficient time to develop adequate information about the operation of the new 223 limits.

SUMMARY OF RECOMMENDATIONS

The following specifications outline the basic criteria AARP considers important in evaluating a prospective reimbursement plan. Recognizing that runaway costs in the health care sector, particularly hospital costs, is the engine powering the drive to a prospective payment system, health care costs containment and quality care must be the major goals of the new system. The specifications outlined below are committed to those goals. Moreover, they address critical financing problems for innercity and teaching hospitals, yet allow states the flexibility to achieve health care sector savings under their own prospective payment plan.

1. *Coverage.*—The system should cover all payors, all services and all hospitals. Otherwise, there will be cost shifting.

Exemptions from coverage should be allowed when coverage results in higher costs to the system.

2. *Basis of Payment.*—The basis of payment that offers the best chance for developing a meaningful pricing mechanism is diagnostic related groupings (DRGs). It is essential that the payment formula include a severity of illness index, provisions for teaching hospitals, uncompensated care and capital funding. The DRG rates should be reviewed periodically and adjusted according to a preestablished formula.

3. *Assignment.*—Mandatory for hospitals and for physicians employed or contracting with hospitals. Development of stronger incentives to encourage other health care providers to accept assignment.

4. *Utilization review.*—There must be a strong utilization review capability that includes adequate consumer representation and enforcement powers.

5. States should not be forced into a single prospective reimbursement plan. Within broad guidelines specified by HHS, states should be permitted to develop alternative plans as long as the savings projected are equal to or greater than the savings under the federal plan.

6. Prospective payment legislation should not be put on a fast track or developed as part of the fiscal year 1984 budget process.

Chairman **JACOBS.** Mr. Moore?

Mr. **MOORE.** No questions.

Mr. **DUNCAN.** I have no questions. I want to thank the panel for their contribution.

Mr. **SHANNON.** No questions.

Chairman **JACOBS.** We thank the panel for its contribution.

Health Insurance Association of America, represented by James L. Moorefield.

STATEMENT OF JAMES L. MOOREFIELD, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, ACCOMPANIED BY MICHAEL SCHIFFER, DIRECTOR OF GOVERNMENT RELATIONS, CIGNA CORP.; AND KAREN WILLIAMS, WASHINGTON STAFF REPRESENTATIVE

Mr. **Moorefield.** Mr. Chairman, gentlemen, I am James Moorefield, president of the Health Insurance Association, also known as the HIAA. With me today, on my right, is Michael Schiffer, director of government relations of the CIGNA Corp.; and to my left, Karen Williams, one of our Washington staff representatives.

The HAA agrees that a change to a system of prospectively determined hospital prices is highly desirable. Any system that does not apply to all patients will not produce cost conscious hospital behavior.

In practice, unless all patient revenues are prospective, hospitals will find it far easier to cost shift than to cost contain. Without an all-payor system, private patients will remain vulnerable to $6 billion more annually of cost shift, an unprecedented and fiancially intolerable burn placed on the private sector as a result of government action.

Now, an all-payor system does not necessarily require that all-payors pay the same price for each DRG. But any discount recognized or granted by a hospital ought to be justified by savings to that hospital. And it should be available to any payor who can qualify under an established criteria.

Now, as was suggested by the spokesman for the Federation of American Hospitals earlier, and you may ask whether commercial insurers can negotiate with hospitals to accept less than the full payment of their charges. The practical answer is, which I am sure you understand, that our industry, our numbers of companies, are too dispersed to negotiate individually. And we are protected by antitrust laws from negotiating jointly.

Just to make the point, there is only one commercial insurance company in this country that has as much as 4 percent of the national market. Experiments with State prospective payments systems clearly demonstrates their effectiveness in containing aggregate health care costs. States should have the flexibility in the design of their own all-payor prospective payment plan so as to meet the individual State's needs.

However, the administration now seeks to force all interested States into a payment on only a DRG basis. In TEFRA, Congress established guidelines for permanent State waivers. As you are probably aware, the draft regulations to implement that provision have been sent to OMB, and they require DRG. The DRG requirement is so specific in fact that of those few States now operating under a prospective payment plan, only New Jersey would continue to qualify. Massachusetts, New York, and others would no longer qualify under those proposals.

It is unjustifiable, therefore, to force a single design on all States.

Now, while we support prospective reimbursement, our association has some concerns about the medicare-only system as has been proposed.

We fear, as others have expressed, that large public and teaching hospitals will be systematically disadvantaged. Remember, medicare will not be financing the new profits, but other hospitals will through greater losses.

Most hospitals will then have to look to the private patient to bear those losses through even greater cost shifting than is being experienced today.

We advocate taking the time to devise appropriate adjustments to the medicare proposal to address these inequities. Since TEFRA already provides the same aggregate medicare savings as is proposed, the budget does not require hasty action on prospective payment.

In summary, Mr. Chairman, and gentlemen, we do support a change to a system of payment for hospitals with prospectively determined prices, and we can support DRG as one acceptable unit of payment. However, we support such a system only if it applies to all patients and to all-payors, and that there is a strong emphasis on State alternatives.

To summarize, Mr. Chairman, we request and recommend that the prospective payments system be applied to all-payors, if for some reason not at this moment, then phase it in for a date certain.

Second, we ask that the State option for medicare payment enacted last year by the Congress be strengthened and clarified. And third, that the insurers be specifically authorized to engage in joint health care cost containment activities, such as sharing data, such as negotiating with health providers, and developing computerized profiles on patterns of care.

Mr. Moore, we would add that would include the disclosure of the hospital rates which you were earlier asking how they could be resolved.

[The prepared statement follows:]

STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, PRESENTED BY JAMES L. MOOREFIELD

I am James Moorefield, President of the Health Insurance Association of America. I am appearing today on behalf of our 338 member companies which cover over 90 million Americans for hospital expenses.

We are pleased that you are raising the issue of hospital reimbursement reform early in the 98th Congress. This important and complex issue requires thoughtful and balanced debate. We appreciate the opportunity to add our industry's views, both on the general issue of how hospitals should be paid and, in particular, on the proposal recently announced by the Department of Health and Human Services.

The HHS proposal serves as a good starting point for discussion of the issues. It would change hospital payment from the present retrospective determination of incurred costs to a system of prospectively determined prices. We agree that this change in incentives is highly desirable. In fact, prospective payment may be our last chance for a competitive solution to rising hospital costs. However, the HHS proposal applies only to Medicare. Any system that does not apply to all patients will not produce the desired changes in hospital behavior.

We believe that any prospective payment system enacted by the Congress should: Apply to all patients and all payers, not just to Medicare, and explicitly provide for prospective payment programs at the State level which may be designed to best meet the specific needs of all patients in that State.

The change in payment basis under Medicare would probably not have been proposed were it not for persistent, rapid increases in health care costs in recent years. These increases and their effects on government programs are just as applicable to the insurance coverage purchased by employers for their employees, by individuals for themselves, and by the self-insured. As a result, health insurance premiums are increasing annually at rates which range from 20% to 40% depending on the size and location of the business. These increases are ultimately shared by the employers, employees and consumers and adversely affect the health of American industry.

A prospective pricing system which applies only to Medicare will admittedly hold down Medicare outlays, but it could permit hospitals to shift to other payers an additional $6 billion from recent federal cutbacks. If the change to a prospective system provides the right incentives to hospitals to voluntarily control health care expenses, and we agree that it does, such a change is equally needed by those who are not eligible for Medicare.

The participants in the health care marketplace agree that present incentives in the hospital industry are misplaced. A hospital doesn't profit when it reduces costs by one dollar because it loses one dollar of income. In short, the current cost-based system requires hospitals to spend more in order to get more. Those of us in the health insurance industry know that the current reimbursement system offers a blank check to hospitals. In recognition of the many shortcomings of the current system, the major hospital trade associations are on record in support of system reform based on prospectively-determined prices.

Prospectively determined hospital prices can begin to introduce competitive forces into the health care market. Hospitals should be able to project their income and should be at risk; that is, able to generate profit through increased efficiency. These concepts are basic to most industries, including the insurance industry. Accordingly, prospective payment makes sense not only for Medicare, but for all patients. A Medicare-only system may save money in the federal budget in the short run, but the long term increase in aggregate health costs will continue for two reasons—cost-shifting and contradictory incentives. A fragmented market, combining the old "spend more" incentives for most patients and the new "spend less" incentives for some patients, cannot possibly contain costs. Hospitals whose management practices continue to drive costs above the Medicare rates will shift those costs to other patients.

The existence of cost shifting has become well-documented since our industry publicly identified the problem a couple of years ago. Until recently, the phrase "cost shift" referred only to those kinds of business expenses incurred by virtually all hospitals but excluded from the calculation of Medicare payments. Such costs of business include uncompensated care, research and working capital. This form of cost shift totaled $5.8 billion in 1982. But, in the last few years, a new form of cost shifting has appeared as Medicare and Medicaid payments are reduced for costs that HCFA acknowledges are for treatment of government patients. Such reductions totaled $1 billion from 1974 until 1982. Such reductions will total more than $6 billion from 1983 through 1985. As a logical business practice, hospitals recoup reductions in Medicare and Medicaid reimbursement by inflating charges to private patients. Without government action on an all-payer system, these private patients remain vulnerable to an unprecedented and financially intolerable level of cost shifting.

In theory, prospective payment leads to cost containment because hospitals will work with physicians to voluntarily reduce length of stay and ancillary services. The incentive for such behavorial changes is profit; hospitals will finally be able to get more money for doing less. But hospitals say such changes take time and substantial effort. In practice, hospitals will find it far easier to cost shift than to cost contain.

We could support any federal legislation that effectively protects private patients from additional cost shifts. Such protection could take one of several forms. We would be happy to work with you on immediate adoption of such protections. One option would be a residual prospective payment system for all-payers. While such a system would provide cost containment incentives, it need not produce savings to the private sector in the short-run. Furthermore, an all-payer system would not necessarily require that all-payers initially pay the same price for each DRG. But discounts ought to be justified by savings to the hospital and be available to all patients. For example, discounts for prompt payment would be appropriate. Government patients in Maryland are an exception to this principle. While sharing in all costs to the hospital including uncompensated care, they receive an additional discount in order to stay within the aggregate federal cap required under the Medicare waiver.

I would like to shed some light on arguments against an all-payer system. The Administration says that we private insurers will piggyback on the Medicare DRG prices once we recognize that we are paying too much for hospital care. Mr. Chairman, we already know we are paying too much but we are unable to pay less under a combination of current federal policies that generate cost shifting while prohibiting joint negotiation by insurers. We are caught between the competitive forces in the insurance market and the failures in the non-competitive hospital industry. Current comprehensive benefit contracts with employers would prohibit us from lifting our payments to hospitals to the Medicare rate because hospitals would bill employees for the difference. Employers and employees have made a conscious decision to elect comprehensive medical benefits in 90% of our group business.

If, in the future, an individual insurance company only offered to sell plans which limit benefits to the Medicare DRG rates, employers would again exercise their option in the free market to buy comprehensive benefits from another insurance company. What if the federal government intervened in the competitive health insurance market and prohibited the selling of comprehensive medical benefits; would you then indirectly succeed in controlling hospital costs? No, hospitals would charge patients all that the market would bear above the indemnity amounts. Many hospitals would soon find their solvency threatened as bad debts mounted.

You may ask whether we negotiate with hospitals to accept less than their charges as full payment. Hospitals have agreed to such requests to voluntarily reduce their revenues only where an employer or insurer has sufficient volume to force acceptance. Some Blue Cross plans and the Rochester-employer coalition so dominate their local areas as to be successful in obtaining such volume discounts. For the vast majority of the country, however, neither the insurance company nor the employer has sufficient local volume to negotiate charges and thereby prevent cost shifting. To drive home the point, 4 percent is the largest area market share enjoyed by the Prudential, which is the single largest private health insurer in the country. We are too dispersed to negotiate individually and we are prohibited by antitrust laws from negotiating jointly.

Experience validates our frustrations over cost shifting. Experience has also shown that second-opinion surgery, ambulatory benefits and other coverage designed to reduce utilization are successful but alone have limited impact. Finally, experience with State prospective payment systems clearly demonstrates their effectiveness in containing aggregate health care costs.

This is a developing area and no one yet can claim to have all the answers to the questions of a single hospital payment reform system. In fact, two of the oldest and most effective systems, the Maryland and New Jersey programs, operate quite differently. HHS recently granted waivers to New York and Massachusetts, two of the nation's high cost states. In both of these states, all parties with a direct stake in hospital payment change—providers, employers, unions and insurers—actively participated in designing a solution. Both are implementing approaches different from those in Maryland and New Jersey. We believe all of these different approaches will lower costs and produce useful comparisons.

We believe that there should be flexibility at the State level in the design of prospective payment systems. Despite broad statutory authority for demonstrations and for permanent waivers, the Administration now seeks to force all interested States into payment on a DRG basis. The rules under the previous demonstration authority were revised last October to require DRG's. In TEFRA Congress established guidelines for permanent State waivers. Draft regulations to implement that provision are in clearance and also require DRG's. The language is so specific, in fact, that only New Jersey could qualify for a waiver. Other States could not qualify despite their use of case mix measures and, in some systems, even DRG's. It is premature of HHS to propose nationwide implementation of an untried system for Medicare. It is unjustifiable and a pre-emption of new federalism to force a single design on all States that want to contain costs for all patients but especially on those States that have pioneered successful alternatives and will need renewal.

The federal government's past role as a catalyst has helped encourage variety and innovation. We believe this is the prime role for the federal government, and should be continued. We urge that any legislation you adopt provide incentives to States to develop their own programs for all patients and not require a single payment method such as DRG's.

While we support prospective reimbursement and believe DRG's are one viable model for an all-payer system, we have some concerns with the Medicare system as proposed. Based on our preliminary review and the testimony of public hospitals and teaching hospitals, we fear that these institutions will be systematically disadvantaged compared to other hospitals. We also fear that hospitals in the inner cities and in large cities will be systematically disadvantaged. It would be unthinkable to suddenly redistribute large amounts of Medicare revenues to finance greater profits to proprietary hospitals and small hospitals in the sunbelt at the expense of large, public and teaching hospitals in the older industrialized States. Remember, Medicare will not be financing the new profits, other hospitals will through greater losses. Most hospitals will look to private patients to hear these losses through even greater cost shifting. For public and teaching hospitals, where far fewer patients have private insurance, financing windfall profits to other hospitals could precipitate a fiscal crisis. We advocate taking the time to devise appropriate adjustments to the Medicare proposal to address these inequities. Since TEFRA already provides the same aggregate Medicare savings, the budget does not require hasty action on prospective payment.

In summary, we support the change to a system of payment for hospitals with prospectively determined prices and can support DRG as one acceptable unit of payment. We support such a system only if it applies to all patients and all payers with a strong emphasis on State alternatives. We believe that the nation will be best served if any legislation contains incentives to encourage prospective payment systems at the State level, where such systems can be tailored to meet local economic and health care needs.

Therefore, Mr. Chairman, we specifically request and recommend:

1. for the prospective payment system to apply to all payers, if not now, then phased-in at a date certain;
2. that the State option for Medicare payment enacted last year be strengthened and clarified; and
3. that insurers be specifically authorized to engage in joint health care cost containment activities, such as sharing data, negotiating with health providers, and developing computerized profiles on patterns of care.

Chairman JACOBS. Thank you.

Mr. Moore.

Mr. MOORE. Thank you, Mr. Chairman. I fully agree with you on the problem of cost shifting. This concerns me greatly.

You understand the predicament of this committee. We don't have the jurisdiction to deal with universal coverage for private payers or all-payers. We are limited strictly to medicare. Let me ask you this.

Assuming that is the best we can do, do you think that there is any way that the DRG system would become a basis that private insurance companies on their own would begin to accept as the norm and begin to say this is what we are going to pay in negotiations with hospitals?

Mr. MOOREFIELD. It is probable, but highly unlikely. The contracts out there now are as you know written on a group basis primarily, negotiated contracts, and they are providing for reasonable and customary charges. It is possible that one or more companies would go to a DRG basis. But with competition being what it is among the many companies that are in the business, some fears, the first employer that asked for the continuation of the reasonable and customary would be granted that.

Mr. MOORE. Is there a movement among employers today to go for lower option plans because of the expense?

Mr. MOOREFIELD. Yes, sir. In fact, our industry in the past, we are vulnerable to this—all the criticisms of increasing costs too, because our industry promoted first dollar coverage. That pendulum has swung back, and over 90 percent of our group cases issued today have deductibles and coinsurance. And we see the pattern that those are increasing in amounts at the employers' and at the insurers' negotiation and request.

Mr. MOORE. That was my thought, that this trend would continue, except the insurance companies would now have a new weapon to use in addition to the pendulum swinging in that direction. You could use the DRG rate or something like that, to assist you in your work. I understand your problem.

The cost shifting thing I consider a very grevious problem, one we are very much concerned about.

Thank you very much, Mr. Moorefield.

Mr. SCHIFFER. May I add one thought. On the question of competitiveness and disclosure, Mr. Moore, it seems to me that if we had better access to what hospital costs were really all about, we would have a better opportunity to construct the kind of plans that would in fact induce competition between hospitals. I am thinking specifically, for example, if we knew what the DRG costs were for all-payers, not just for the private, not just for the medicare patient, we could then construct the kind of contract that would encourage patients to go to a hospital where the DRG costs were lower.

So it could be that an important part of this initial piece of legislation could be a requirement that there be some further disclosure of hospital costs for all-payers.

Mr. MOORE. That is something to consider. I will have to consult with our committee counsel. I understand your viewpoint. What we are hoping of course is that through competition you will eventually construct private negotiation, which admittedly is extremely difficult now, but as there is now a cost-consciousness among employers, also, you will now have a DRG rate out there, even though it is not for all-payers perhaps, you will be able to go to a hospital and say we will negotiate with you. We hope that will become an emerging trend, just as getting away from the first dollar payment has become an emerging trend.

Mr. MOOREFIELD. A single company now cannot do that. It does not have the leverage, and laws do not let us do it jointly.

Mr. MOORE. There is an emerging trend in your industry to be competitive with the employer you are dealing with. The next phase of the negotiations with General Motors might be, look, we would like to go to a DRG rate, and we can reduce your rates accordingly if you will do that. Then before you do that, you have to have made an arrangement with the areas where your policyholders would be, and with an institution that would accept the DRG rate. That is more complicated.

But it may be the best we can do out of this subcommittee. Thank you.

Mr. DUNCAN. I have no questions, Mr. Chairman.

Mr. SHANNON. No questions.

Chairman JACOBS. Mr. Moorefield, we thank you for your testimony.

The next panel consists of Faith Goldschmidt, research specialist with the New Jersey Department of Health; Robert M. Crane, director, New York State Office of Health Systems Management; Harold A. Cohen, executive director of the Maryland Health Services Cost Review Commission; and Nicholas P. Desien, vice president of finance for the Maryland Hospital Association.

STATEMENT OF HAROLD A. COHEN, EXECUTIVE DIRECTOR, MARYLAND HEALTH SERVICES COST REVIEW COMMISSION

Mr. COHEN. I am Harold Cohen, executive director of Maryland's Health Services Cost Review Commission. I would like to enter into the record a copy of the statement which was given to you. I also have an additional single page which I would like to add to my testimony as a result of some information that was brought to my attention after the deadline for submitting testimony.

As a result of the time I would like to basically summarize my testimony.

First I would indicate that the testimony endorses the replacement of retrospective cost-based reimbursement by a prospective payments system. Incentive-based prospective payments systems can change hospital behavior by putting hospitals at risk for both the cost of individual departments and the way medicine is practiced in the individual hospital.

The major cost questions relate to length of stay and the intensity of treatment, and the cost of treating patients with different diseases varies considerably. Thus the Department's choice of the case-mix adjusted admissions as the payment unit is correct and the new DRG's are, in my opinion, the best available means of making such case-mix adjustment, so that the choice I think is an appropriate one.

While Congress should adopt the major portions of this proposal it should also recognize that the major social problem is the proportion of our resources going to hospital care. Congress should support activities designed to prevent cost shifts from the citizen's tax pockets to their other pockets. This testimony includes several specific recommendations to modify the Department's proposal in order to better control health care costs.

Specifically, Congress should support State activities designed to contain hospital costs while maintaining an equitable payments system subject to the requirement that State programs meet federally specified performance criteria.

In particular, I would suggest that States not be given a tougher target to meet while trying to control cost shifting than medicare has to meet for the country as a whole.

Second, I would suggest that, on the basis of all the demonstration projects, that the bill should include a volume adjustment formula or some other protection against increased admissions as well as interhospital transfers and readmissions. I suggest specifically that one possibility is in lieu of using the admission as the basis of payment, to instead use the spell of illness, which is information in medicare's records. That way if a patient is readmitted or transferred from one hospital to another, that will all be treated under one treatment, and medicare will not pay twice for the same admission.

My second suggestion follows from my concern about the capital passthrough. I suggest, as I have several times in the past, that medicare should establish 223-type limits to limit the amount of money that would be paid under capital. Right now we essentially have a passthrough of capital cost and financial feasibility has no meaning if anything that is incurred is paid. So that while you are not ready to go prospective on buildings, for example, I think HCFA could go prospective on equipment, and that you could have 223-type limits to say in advance what will be paid for capital.

Second, I am quite concerned about the impact that the proposal will have on the medicare budget as it relates to outpatients. There should be some limit set to the increases for outpatient care. Hospital accounting is an art, and hospital accountants are artists at shifting costs to where they get paid. And if you pay prospectively for inpatient care and pay retrospective costs for outpatient care, I believe they have greatly underestimated what the cost to you will be of shifting costs to the outpatient arena.

I would suggest some kind of alternative approach such as saying that you will pay something along what the market pays for nonhospital providers, for various types of outpatient care.

The next thing I would point out is that while an arrangement is made whereby patients are divided into 356 different categories, workers, hospital employees, are divided into 1 category. Specifically, the wage adjustment that is used in the system is not a very good one.

For example, it suggests that the wages, hospital wages, in Syracuse, N.Y., are 43.6 percent higher than they are in Rochester, N.Y., which is less than 2 hours away. There is no way the market would sustain that. The reason for that is that the measure is not a very good one. The measure that medicare has presented for making corrections between labor markets is dependent upon such things as whether a particular labor market, hospital market, uses a lot of parttime employees, whether they happen to be in a market with a lot of nursing homes or not.

I suggest an alternative solution to that particular problem, and that is to have data collected so a job mix adjusted hourly payment information can be used.

In the meantime, as my additional page suggests, I would suggest rather than have a national limit, that I would tend to come down to the side of the AHA proposal of having an individual hospital cost limit, although I would not pass through teaching costs if that were done, that is teaching costs are in the individual hospital cost base.

I would also ask you if you have a teaching hospital passthrough that you recognize an alternative or an additional reason for making additional payments to teaching hospitals. I am concerned that the proposal will be looked at and found faulty in why it suggests that teaching hospitals should get more than the average DRG rate. I would suggest to you that an additional reason to give them more money for the average DRG rate is a technical reason having to do with the MEDPAR data base.

Essentially, ordinary medicine is routinely undercharged and esoteric medicine is routinely overcharged. Teaching hospitals do much of the esoteric medicine, and so that is not averaged out in the MEDPAR calculation that HCFA has done.

So what you get is the teaching hospitals in effect paid too little for their esoteric medicine without the correct markup otherwise. So I would suggest that that markup is necessary.

Next I would suggest that you have to protect against double payment by directing medicare to only pay hospitals for inpatient services eligible for payment under part A. The proposal indicates that they are going to be watching for people to unbundle inpatient services, that is to shift such services as the radiology department to a separate leased organization which will bill medicare under part B.

I would suggest the intermediaries will not find the change. They will be using different intermediaries, and intermediaries are going to be busy doing other things. I would suggest that since hospitals make the decision to lease out those properties, they should be given the money and they should arrange the payment for them.

And finally, I would suggest that you adopt changes in the tax laws so that expenditures on health care compete more fairly with other forms of expenditures, compensation, and investment, and will give the other payers much more need to fight back when hospitals try to shift their costs.

Thank you very much.

[The prepared statement follows:]

Statement of Harold A. Cohen, Executive Director, Maryland Health Services Cost Review Commission

SUMMARY

This testimony endorses the replacement of retrospective cost reimbursement by a prospective payment system. Incentive-based, prospective payment systems can change hospital behavior by putting them at risk for both the cost of individual departments and the way medicine is practiced in their hospital. The major cost questions relate to length of stay and the intensity of treatment. The cost of treating patients with different diseases varies considerably. Thus, DHHS' choice of case-mix adjusted admissions as the payment unit is correct and the new DRGs are the best available means of making case-mix adjustments.

While Congress should adopt the major portions of this proposal, it should also recognize that the major social problem is the proportion of our resources going to hospital care. Congress should support activities designed to prevent cost shifts from the citizens' tax pockets to their other pockets.

This testimony includes several specific recommendations to modify the DHHS proposal in order to better control health care costs. Specifically, Congress should:

1. Support State activities designed to contain hospital costs while maintaining an equitable payment system, subject to the requirement that State programs meet federally-specified performance criteria.
2. Institute a volume adjustment formula and/or protection against inter-hospital transfers and readmissions.
3. Set a limit to the increase allowed under the capital passthrough and make equipment payments on a prospective basis.
4. Set a limit to payment increases for outpatient care to protect against cost allocations designed to remove costs from the inpatient control system.
5. Use job mix-adjusted hourly payment information to develop the wage adjustment.
6. Recognize an alternative or additional reason for additional payments to teaching hospitals.
7. Protect against double payment by directing medicare to only pay hospitals for inpatient services which are eligible for payment under part A.
8. Allow States with data bases superior to medicare's to use that information through continued payment waivers.
9. Adopt changes in the tax law so that expenditures on health care compete more fairly with other forms of expenditures, compensation, and investment.

STATEMENT

Mr. Chairman and members of the committee: Good afternoon. My name is Harold A. Cohen and I am the executive director of the Maryland Health Services Cost Review Commission. The Commission is a State agency created in 1971 which has been setting prospective hospital rates for Maryland hospitals since 1975. Since July 1, 1977, these rates have applied to medicare and medicaid by authority of a waiver agreement entered into with the Health Care Financing Administration (HCFA) under section 1814(b) of the Social Security Act Amendments of 1972. According to data mutually agreed upon by us and HCFA as part of our evaluation (or "CAP") test, the Maryland prospective system has produced substantial savings—$74,000,000 for medicare and $49,000,000 for medicaid. Moreover, these savings have been achieved without harming hospital financial viability. Since July 1977, when medicare and medicaid joined our system, hospital profits increased, and hospitals treating large numbers of indigent patients have been placed on a far more secure economic foundation.

Let me make a few brief descriptive comments about our system before I comment on the medicare proposal. First, we operate an all payor system whose aim is to contain the total resources consumed by the hospital sector. Second, we rely heavily on financial incentives to motivate desired changes in hospital behavior. We believe there is nothing inappropriate in any hospital—proprietary or non-profit—making profits if these profits are achieved through efficiency. Finally, we believe that there is something wrong in financing huge increases in hospital costs every year when other equally important social needs are bearing the brunt of resource cutbacks.

You are probably interested in the extent of savings achievable in a prospective hospital payment system. We in Maryland recently disseminated the results of our system for the fiscal year ending June 30, 1982. This disclosure report is traditionally presented at the HSCRC's February meeting. While the national average increase in cost per day was 17.0 percent, the rate of increase in Maryland was 14.2 percent. This amounts to a savings, from that perspective, of $39.5 million. From the more important perspective of cost per admission, the national increase (as supplied by the American Hospital Association) was 16.7 percent. Maryland's rate of increase in cost per admission was 12.1 percent. This difference amounts to a $68.3 million savings for Maryland versus the national experience. If our system's results were compared to those of non-regulated States, our estimated savings per admission would be 51½ percent or approximately $80 million. Since Maryland accounts for only 2 percent of the Nation's hospital expenditures, the savings potential indicated by extrapolating our approach to other States is very substantial. This potential is enhanced by the fact that our relative savings were achieved by further constraining a cost base which has been regulated for six years. The cumulative system-wide savings generated in Maryland over the past seven years is approximately $1 billion on a total State/Federal expenditure of approximately $9 million. These seven years have seen Maryland's hospitals reduce their costs per day from 20 percent above the national average to slightly below the national average while improving their management and their fiscal solvency. Thus, my following remarks concerning the proposed medicare prospective system are based upon a long and reasonably successful experience with a prospective, incentive-based hospital payment system.

The first important question for you to consider is whether Congress, having directed DHHS to propose a prospective payment system (P.P.S.), should in fact change the medicare payment system from retrospective cost reimbursement (RCR). I strongly urge that you do make this change. Under RCR, a hospital is essentially at risk for nothing. Very few hospitals have been denied anything under section 223 and the upward drift of hospital costs has not been controlled. Under P.P.S., a hospital is at risk for performance which does not meet the efficiency standards used in the development of the prospective rates. As table 1 on page 6 of Secretary Schweicker's report shows, hospitals can control their costs to a much greater extent than RCR requires and P.P.S. gives them far more protection from the "uncontrollable" aspects of the economy than normal businesses with uninsured clients enjoy in these difficult economic times. For several years now, hospital unit costs have been growing more rapidly than inflation and hospital total expenditures have been growing more rapidly than GNP. These growth rates leave fewer dollars available for other social concerns. While hospitals complain that DHHS may not give them enough to cope with inflation or enough money to adopt all sorts of cost increasing technology, other social services—many of which contribute more to the health of the people—are lucky if their budgets increase by half of inflation. While hospitals claim that P.P.S. may make it more difficult for them to borrow to upgrade physical facilities and point to a major capital need for hospitals, the hospital plant in this country is much more modern than our manufacturing, education and transportation facilities. Nevertheless, we give hospitals huge tax advantages in raising funds. Further, by using the prior year's inflation as the forecaster of the next year's inflation, hospitals are paid for inflation over time, sometimes being a little ahead and sometimes a little behind in cash flow.

The next major question is whether a prospective system for medicare will result in reduced hospital expenditures or in a shifting of the burden of paying for increases from medicare to other payors. Some opponents of P.P.S. for medicare argue that hospitals will not change their behavior but will simply shift the cost results of that behavior onto other payors. I agree with those who argue that the important problem in hospital financing is the total level of resources consumed by the hospital sector. I do not believe the value received for the marginal billions spent for hospital care is worth the expenditure. I do not think they make sense whether we pay for them out of our tax pocket, our health insurance pocket, our paycheck pocket, or any other pocket. It is important for you to control what we pay out of our tax pocket but you should also alter the tax laws regarding health insurance and allow other approaches which protect all our pockets. In particular, you should at least permit, and probably encourage, States to meet nationally established expenditure targets within the context of an equitable payment structure. This position agrees with those taken by both the National Governors' Association and the National Council of State Legislators. While we in Maryland are adequately protected by language in the Omnibus Reconciliation Act of 1981 and the notice requirement in TEFRA, other States are not so fortunate. You should direct DHHS to accept State waiver applications so long as the rate of increase in medicare expenditures per admission or per capita does not exceed that which occurs in States without waivers.

Thus, I strongly encourage you to adopt a prospective payment system for medicare, to alter the tax laws, and to otherwise encourage the efficient purchase of hospital care while allowing states to individually respond to your performance criteria. Over time, those criteria should address the major problem regarding total resource use and not simply to the Federal budget problems.

Having strongly endorsed the idea of a P.P.S. for medicare, I will turn to the proposal before you. The first major question in designing a prospective system, as correctly indicated by DHHS, is the selection of the unit of payment. The proposal before you is to pay prospectively for admissions divided into those diagnostic-related groups (or DRGs) for which HCFA has an adequate national sample of cases. People who go to the hospital are concerned about their total charge, not about the charge for each individual service or for each day of care. Two days at $300 per day is preferable to three days at $250 per day. In Maryland we have found that hospitals can control length of stay and it is appropriate for medicare to adopt a payment unit which encourages length of stay control. Thus, the case-mix adjusted admission is much superior to the patient day. The problem, of course, is that hospitals tend to provide more of whatever unit is being purchased. Therefore, you should reject the proposal of a 100 percent variable cost for additional admissions and set a payment formula which protects medicare from unnecessary admissions. Do not rely solely upon PROs. Further, the admission system should not pay several times for the same course of treatment, either because of inter-hospital transfers or because of re-admissions. While medicare's hospital discharge data set does not identify whether a patient has been discharged to another hospital or re-admitted for the same diagnosis, medicare's subscriber records maintain data on what is referred to as a "spell of illness." I propose that the hospital portion of one "spell of illness" should be the payment unit with multiple admissions sharing the payment for that one course of treatment. At a minimum, some protection is needed against inter-hospital transfers. These often make medical sense but they do not make fiscal sense if both hospitals receive a full DRG payment. You should also note that several States, including Maryland, have a much richer data base than medicare. These data bases include 100 percent of medicare discharges, have enough data to use all DRG's, and can identify transferred and re-admitted patients. Thus, it makes sense for HCFA to consider using these data bases to do studies and to allow those States to use their superior data bases for medicare purposes.

With regard to the question of casemix adjustments, I also agree that DHHS chose wisely when they selected the new DRGs as the national casemix measure. They are the best of the currently available choices. However, one major advantage of paying by the admission is to involve the medical staff. In some hospitals, an alternative casemix grouping may fit better with the medical staff organization. States which want to take advantage of that situation should be permitted to do so.

In addition to supporting the choice of payment method and the choice of payment unit, I believe DHHS is correct in seeking to apply the system only to short-term hospitals. The system, however, should be applied to new hospitals as well as old. The P.P.S. rates are market constraints analogous to the market prices which new firms must meet in competitive industries. There are few locations in this country which really need additional hospitals. You should also be very careful not to permit a situation in which some hospitals in a community are being paid prospectively while others are still being paid on a retrospective basis. The 100 percent variable cost adjustment which is suggested in the medicare proposal will give 100 percent marginal revenues for additional admissions in prospectively paid hospitals without requiring retrospectively paid hospitals to reduce costs when they lost patients. Without a modification of this approach, your payments may escalate substantially because of unnecessary admissions and patient-shifting among local hospitals.

In addition to suggesting that you adopt a volume adjustment designed to encourage lower utilization, I would propose some other technical adjustments which may have a significant financial impact. The proposed P.P.S. system includes a "passthrough" of capital costs. While more thought is needed to develop a prospective system for the capital costs associated with buildings and fixed equipment, a prospective system for movable equipment could be adopted at this time. I have attached a proposed Maryland policy on equipment as an appendix to my remarks. Further, you should set a limit to the potential cost impact of capital projects while a long term prospective solution is being developed. Perhaps section 223 type limits on capital cost could be added to prospective payments for operating costs. Hospitals should be permitted to select their own mix of labor and capital in the production of patient treatments without a change in payment for the product. The Rochester Area Hospital Corporation, in Rochester, New York—a system which operates under a medicare waiver—has begun efforts to develop a prospective payment system for capital. They, too, are concerned that a passthrough capital system does not consider affordability or encourage prudent financing of hospital capital stock.

A second concern is the continuation of cost-based payment for hospital outpatient activities. One of the lessons of Maryland and many other States is that the allocation of costs is an art rather than a science. Hospital financial officers are adept at the art of allocating costs where they will get paid. The potential for shifting costs from inpatient to outpatient is enormous especially since the current payment system tends to encourage overallocations to inpatients. Hospitals are already much more costly providers of outpatient care than non-hospital providers of similar services. This provision will encourage hospitals to open or expand where they should be contracting. I propose that a section 223 type limit or prospective limit on outpatient services be adopted with the standard of reasonableness keyed to the cost of non-hospital providers. A special provision can be made for the specialized clinics of teaching hospitals. It is important to remember that community services do not develop in the shadows of hospital outpatient departments, and that failure to control hospital costs reduces the funds for social services to those populations ostensibly protected by hospital outpatient departments.

My third concern relates to the adjustments for teaching hospitals. The proposal contains two adjustments for teaching hospitals—a direct cost adjustment to reflect the cost of interns and residents and an indirect cost adjustment to reflect the more costly medical practices which are associated with medical education. In fact, the direct services of residents and interns are often a bargain for those who receive them. It is not patients who are subsidized by these services and payments; instead, it is attending physicians, who often receive their full pay while shifting much of the burden of care to the residents, who are subsidized. Much the same can be said for full-time paid non-resident house staff. P.P.S. should make an adjustment for real teaching activities and for medical services but should be wary of paying for the same service under medicare part A and part B.

According to the DHHS proposal, the indirect cost adjustment is being made because teaching hospitals do more ancillary testing and keep patients for longer periods. The Department's concern is that their data base cannot distinguish the difference in severity within diagnostic groups from simple inefficiencies. Our major teaching hospitals do need protection from unadjusted DRG payments. They are subject to a more intense patient mix and the system of hospital charging required by medicare and the basis for DRG relative prices works against them. All patients are charged the same amount per day for routine services unless they are in intensive care. Most hospitals also charge similar amounts for time in the operating room, regardless of whether a simple or complex procedure is being performed. Similar examples exist in other departments. Thus, teaching hospitals routinely overcharge simple cases and undercharge very complex cases. The proposed system, if unadjusted, would not pay them the overcharge for routine cases because the national average sample contains many hospitals which only perform routine services at uninflated costs. Since almost every hospital which performs complex surgery underprices that surgery, the averaging method will assign too low a relative price for complex cases. New [illegible] New Jersey and Maryland—all States with prospective rates—have developed or are developing DRG-related nursing charges as an improvement upon uniform routine charges.

My fourth observation regards the treatment in the P.P.S. of wage rates. First, the DHHS hospital market basket has historically measured the rate of increase in hospital wages. Thus, if hospital wages increase more rapidly than other wages, that higher rate of escalation is passed through into hospital payments. Hospital wage rates are no longer lower than wages in comparable positions and their inflation should be no more than general wage rate increases, especially when they are passed through without requiring productivity increases. Several non-hospital wage inflation indices could be used in place of hospital wage experience. Maryland uses the rate of increase in average hourly earnings of production on non-supervisory workers in service industries to set reasonable standards for hospital wage increases. Why should the medicare part A finance wage increases with are higher than those which can be absorbed in other parts of the Federal budget?

The second wage-related problem is the matter of how to make wage rate adjustments for hospitals in different labor markets. This is important because wage related costs amount to 80 percent of hospital costs. (p. 87). The DHHS proposal states, on page 44, that the wage rate adjustment will be "based upon hospital wage information." This is a great improvement over the previous system of using area per capita incomes to adjust hospital wage levels. However, it should be noted that some areas make substantially greater use of part-time employees than others and that a community's job mix varies much more than hospital job mixes. According to the proposed DHHS system of wage adjustments, hospitals in Rochester, New York would get a near average wage factor because of the local mix of employment in these jobs and the local pattern of part-time employment. Meanwhile, hospitals in Syracuse, New York—less than two hours away—would get a wage factor which is 43.6 percent higher than the Rochester factor. I simply cannot believe that hospital wage costs are 43.6 percent higher in Syracuse than they are in Rochester. It is not appropriate to go to the refinement of using 356 DRGs to stratify casemix without doing a better job of making job-mix adjustments for the purposes of comparing labor costs. States with medicare waivers have developed useful methods of performing more sophisticated adjustments.

Next I will address the section regarding part B services on p. 49. Last year I testified that TERFA limits should provide for reductions in the base cost when hospitals lease out the so-called "technical" portion of laboratory, X-ray and the ancillary departments. That suggestion was incorporated in TERFA. I believe the rather vague promise to monitor this problem under P.P.S. will not be sufficient to protect the trust funds from this "potentially serious problem". Different providers can often choose different intermediaries and intermediaries will be very busy examining the shifting of costs into pass-through categories—especially capital and outpatient care. Thus, to solve this problem I propose that only hospitals be paid for the "technical" portion of X-ray, laboratory and the medical services provided inpatients. Let hospitals, which allow these services to be "contracted out" work out the financial arrangements with the service providers. This would have the added incentive of making hospitals prudent buyers of these services on medicare's behalf.

Finally, I would like to say that the Maryland Commission has worked closely with HCFAs Office of Research and Demonstrations and with their Office of Research. Both these offices are staffed with several highly competent individuals who could correct the technical problems which I have highlighted in this testimony.

In summary, it is my opinion that hospital costs are rising far too rapidly and that prospective, incentive-based medicare payments will be a great improvement over retrospective cost reimbursement. Congress should also enact changes in the tax laws governing the hospital market place which will prevent cost shifting. States should be allowed to adopt all payor systems which meet Federal performance criteria, protect all payors, and constrain total hospital resource use. Congress should also make some technical changes in the DHHS proposal before adopting it.

Thank you. I shall be pleased to respond to questions.

APPENDIX

PROPOSED POLICY ON EQUIPMENT

The Commission staff proposes that the Commission adopt a policy in regard to hospital equipment costs and the treatment of rate requests involving equipment purchases. The purpose of the policy is to set in place the appropriate incentives for hospitals to make proper business type decisions in their equipment purchases and to assure that hospitals have appropriate funds with which to purchase equipment. There are three underlining hypotheses which guide the proposed policy. The first hypothesis is that in the provision of health services, labor and capital is often interchangeable. Hospital production can be carried out with significantly different capital labor ratios. The second hypothesis is that hospital management should have the opportunity to choose for themselves the mix of capital and labor which they wish to use to produce hospital output and that that business decision should not influence the rates that can be charged for the patient care promoted. The third hypothesis is that the principal output of hospitals is the treatment of patients with specific ailments.

The proposed policy on equipment takes two parts. The first part relates to policies regarding rate applications and equipment expenditures, and the second part involves proposed changes in the calculation of full financial requirements as they relate to cash needs for equipment.

A. The proposed policies regarding rate requests for equipment

1. The first distinction the staff would make is between replacement equipment and new equipment. The staff proposes that replacement equipment should have no impact upon the rates of a hospital because the hospital's rates already include replacement cost depreciation. The reason for providing replacement cost depreciation for capital is this provides the hospital with sufficient funds to purchase replacement equipment with cash. Hospitals may, for wise business purposes, take advantage of attractive financing opportunities made available by their tax exempt status, but the interest they pay on such borrowing should be at least off-set by the earnings they receive on the non-expended replacement depreciation funds.

2. The second distinction the Commission staff would propose is between business equipment and patient care equipment. Business type equipment involves such things as computerized management information systems, word processing, and equipment associated with hotel type functions of the hospital. This equipment is not used directly for the provision of patient care. The Commission staff would propose that no change in rates be made for the purchase of business type equipment since such equipment should pay for itself through efficiencies. It may be appropriate in an individual circumstance that a hospital, for cash flow purposes, needs an advance on the purchase of such equipment, but in such a case the public should get a pay-back at least equal to the interest rate then in use in the Commission's inflation adjustment system. A hospital which purchases business equipment with its own funds would be entitled to all the savings that that purchase generates, but a hospital which uses public funds would be expected to allow the public to realize a return on the use of those funds.

The next distinction the Commission staff would make is between individual patient care equipment which is used to provide the same services as existing equipment and personnel versus equipment which is used to provide new services. In many cases the first type of equipment purchase is similar to business equipment.

The question of whether to perform laboratory tests with the use of sophisticated equipment or with the use of sophisticated technicians is a choice which hospitals should make without increasing their revenue or decreasing their revenue. The Commission staff believes that decisions within existing departments to substitute equipment, for labor or to purchase additional equipment should not result in rate changes.

Equipment that provides new services should also be divided into two categories. The first relates to services which provide care for illnesses in a different way than they were provided previously and the second are those which provide care for illnesses which the hospital did not previously treat. Examples of the latter would appear to be such things as renal dialysis equipment and radiation therapy equipment. Where the planning agency finds that it is appropriate for a hospital to provide this additional service, then the Commission staff believes that this additional service should result in revenue to the hospital above the simple impact of inflation. Where a hospital chooses to provide the same output through its use of a different mix of departmental inputs, the Commission staff believes that this should not result in additional revenue to the hospital. Some examples of this is the inpatient use of CAT scanners and ultrasound. In both cases, the Commission would approve new departmental rates, but new revenues would not be appropriate except under unusual circumstances. Of course, the GIR provides new service dollars which would not be duplicated.

Finally, it is worth noting that the Commission staff does not believe that the Commission should make any distinction between relatively expensive equipment and relatively inexpensive equipment. The State Health Planning Law establishes a threshold for the purchase of hospital equipment such that hospitals require planning approval to purchase a piece of equipment costing over $400,000 or related pieces of equipment which cost over $400,000 in the aggregate. From the rate review prospective it should make no difference whatever whether a hospital chooses to buy three $200,000 pieces of equipment or one $600,000 piece of equipment out of its equipment budget in a particular year. The purchase of a $600,000 piece of equipment, while requiring planning approval, is not supplementary to, but rather an alternative to, purchase of the three $200,000 pieces of equipment which do not require planning approval. Thus, the Commission should make no distinction in its treatment of equipment based upon whether it is expensive or inexpensive.

Since replacement equipment and business equipment may be quite costly and the expenditures may not be even over time, the Commission may wish to adjust the hospitals equipment flow to reflect the needs when large purchases are to be made. Thus, a hospital with an equipment budget of $800,000 a year which gets planning approval to spend $1 million on one piece of equipment could receive an adjustment in rates which recognizes a cash flow, say, of $1,200,000 the first year and $600,000 the next two years so that at the end of three years the hospital would have received the same total amount of dollars.

Essentially, the above policies propose that hospital equipment be treated as much as possible as business type decisions of hospitals where patients pay according to the illness the hospitals treat and hospital management has the appropriate incentives to provide those services in an efficient manner.

B. Related policies regarding full financial requirements for equipment

The institutions of the above policy should also be accompanied by the institution of what the Commission staff believes is a more appropriate and current determination of the relationship between equipment and financial needs.

1. The staff believes that hospitals should be free to decide how to produce laboratory tests without that decision having any impact on the charges of the hospital. The Commission's current system does not have that property. The Commission's departmental statistic in the laboratory is not interdependent of the way in which a laboratory test is performed. The Commission staff is proposing that the statistics be changed so that hospitals only use the relative value measure associated with manual production of tests. Thus, if a hospital shifts to use of equipment, it will not receive less money by assigning the test fewer relative value units.

2. The general equipment allowance used by the Commission derives from actual equipment expenditures reported in Medicare cost reports prior to the Commission's beginning of rate setting. This amount has been inflated over time. Since that time hospitals have had ample reason to substitute capital for labor and the Commission system has not reflected that substitution. The Commission staff recommends that the Commission establish a new base for the general equipment allowance by doing a new audit similar to the original one.

3. The specific equipment allowance associated with capital intense departments has been maintained on a current basis but several hospitals have shown that they did not correctly report the value of equipment which was fully depreciated prior to their original rate setting. Thus, their replacement depreciation flow has, in some cases, not been adequate to finance replacement equipment. Most hospitals base has been adjusted by now to correct for their original reporting error. The Commission uses a depreciation cycle of 10 years for all equipment except for CAT scanners in which the Commission uses 6½ years. The Commission staff proposes that an audit be made to determine how much the equipment allowance would have to be increased to reflect current lives approved by Medicare and that such an adjustment be made to the departmental equipment allowance for each hospital.

While all these adjustments will provide additional dollars for the hospital industry, the staff believes they are appropriate and will put equipment decisions on a sound financial basis from which hospitals should be financially responsible for their own equipment decisions except for cases in which new patient care outputs are being provided.

Finally, the Commission staff would indicate that two aspects of the inflation adjustment system regarding equipment should also be considered. Currently, the weight used in the inflation adjustment system regarding labor is based upon the hospitals actual labor expenditures as reported in their most recent rate review system while the equipment weight is based on the equipment approved by the Commission. Therefore, hospitals which shift from labor to capital are at a disadvantage. The staff proposes that as a minimum the Commission shift to a system in which the weighting is based on the base approved percentages for capital and labor so that shifts have no influence on the hospitals revenue over time.

The Commission staff would also like the Commission to consider that an industry-wide weight be proposed for capital and equipment so that hospitals are not treated differently in regard to inflation because they have chosen to produce their services in a different manner. The Commission's staff does not have a specific position on this latter point.

Mr. Chairman, since preparing my written testimony, I have had an opportunity to review the proposal prepared by the American Hospital Association. While I believe that proposal suffers from some of the same shortcomings as DHHS (e.g., the need for a volume adjustment) and is inferior to the DHHS proposal in several aspects (e.g., beneficiary liability, small hospitals, ownership changes, inflation and technology, etc.), I believe the AHA's proposed method for establishing DRG specific prices for individual hospitals is, with two modifications, an improvement over the DHHS method. The first modification is that teaching cost would not be a pass-through, but be included in the hospital's base year medicare cost. The second modification would be to establish DRG payment levels for new and relatively new hospitals on the basis of a community average for the operating cost and efficient use of capacity. The first modification means that for the near future, hospital DRG payment differences are not based upon a very faulty wage market adjustment and a convoluted two-part teaching adjustment. It also represents an improvement in handling the distribution of leased departments in the base year. The second modification recognizes that a capital pass-through cannot be the basis for paying absurd amounts to hospitals while they are near empty. If HCFA were prepared to construct separate averages for similar hospitals in the same wage market, I would accept that as a reasonable compromise between the desire to pay the same amount for the same services in the same market and the Department's inadequate proposal for establishing different rates between different markets.

STATEMENT OF NICHOLAS F. DESIEN, VICE PRESIDENT FOR FINANCE, MARYLAND HOSPITAL ASSOCIATION, INC.

Mr. **Desien**. I am Nicholas Desien, vice president for finance of the Maryland Hospital Association. A formal statement has been submitted. For the record, I would like to summarize the key points.

I would like to note that several times Maryland has been mentioned by previous speakers. It is important to recognize that the Maryland Hospital Association, since 1971, has supported prospective payment for all payors. State level governmental regulation of hospital rates for all payors, and full disclosure of the financial affairs of hospitals.

Attached to my presentation is page 120 of Secretary Schweiker's statement which indicates that between 1975 and 1980, Maryland ranked 48 among the States in the percentage increase in expenses per admission. The major reason I would like to testify today relates to the fundamental question of the establishment of the DRG rate itself. There are two basic proposals that have been discussed.

First, the AHA proposal which is the establishment of a hospital specific rate and the movement forward of that rate. The second is the HHS proposal, which is a national average DRG rate. As Hal Cohen has indicated, while Hal has mentioned some modifications to the AHA proposal, Maryland would support the basic concept of the establishment of hospital specific rather than national average DRG rates.

Our reasons are probably best summarized in Dick Knapp's earlier comments. Dick called the HHS proposal expenditure neutral. Fundamentally what he is indicating is that while it is HHS's intent to control the rate of increase in medicare expenditures for hospitals, the national averaging system first and foremost establishes a redistribution of funds, and then once that redistribution is accomplished, it then begins moving forward with the rate of increase.

So the question is given, that, since the Nation's hospitals have established expenditure levels based upon a series of social, economic, political, and medical reasons, is the redistribution methodology proposed in the HHS proposal appropriate?

And, again, I would turn to the CBO testimony this morning, in which it was stated that the administration's proposal would radically change the system of hospital reimbursement on the basis of a methodology that has not been tested and at present appears to be insufficiently refined.

Based upon our experience with the DRG system, and I believe the experience in New Jersey, I think that statement is quite appropriate. The system has not been tested. And to move forward with this untested kind of proposal which could have major impacts on many hospitals throughout the country in terms of the redistribution of funds, we believe would be a mistake.

Finally, as you look at the proposal, in terms of that system, it is sensitive to two major things. One is the wage adjustment. The second is the measurement of intensity. CBO identified that the measurement of intensity has been untested. And we would concur with Dr. Cohen's testimony that the wage adjustment, which is absolutely critical, also leaves a lot to be desired. In our State we have several examples of inequities dealing with that wage adjustment. And I think every other State in the country could identify those.

We have a case in point, Physicians Memorial Hospital, located in La Plata, Md., which has gotten some press lately because of a recent nurse strike at that institution. In essence as a result of the wage adjustment, they would receive a 20-percent higher wage rate component than Calvert Memorial Hospital, which is located about 30 miles away in Calvert, Md., and compete in the same labor market.

In summary, Mr. Chairman, we would endorse the hospital specific DRG rate, as proposed by the AHA. I think that is the most sensible initial step to take in the process of cost control, and believe that the DRG proposal, using a national average, could cause some major redistribution of funds throughout the Nation's hospitals, and could have some catastrophic effects.

Thank you.

[The prepared statement follows:]

STATEMENT OF NICHOLAS F. DESIEN, VICE PRESIDENT/FINANCE, THE MARYLAND HOSPITAL ASSOCIATION, INC.

Mr. Chairman and members of the committee: Good afternoon. My name is Nicholas Desien and I am the vice president for finance for the Maryland Hospital Association (MHA). I am pleased to have this opportunity to testify on proposals for prospective payment for medicare.

By way of background, it should be noted that as an association of hospitals, MHA has, since 1971, supported prospective payment for all payors—not just governmental; State level governmental regulation of hospital rates; and full public disclosure of the financial affairs of hospitals.

I have attached page 120 of the text of the report of Secretary Schweiker to Congress on his recommendations for "hospital prospective payment for medicare." This HHS attachment indicates that between 1975 and 1980 (most current available date), Maryland ranked 48th among the States in percent increase in expenses per adjusted admission.

Given our track record in controlling the rate of growth in per admission expenses (which is the focus of the HHS proposal), we feel qualified to offer some comments on the issues before this committee. We will address our comments to the specific issue of "national vs. hospital specific" payment rates.

In establishing the initial prospective payment rate, two basic approaches have been discussed. It has been proposed that the rates be based on 1. A National average hospital cost per DRG (HHS); and 2. The individual hospital's prior year cost per DRG (AHA).

Although, as a result of our medicare waiver, Maryland hospitals are not directly affected by the HHS proposal, we would nevertheless oppose the use of the national average and, instead, support the use of the individual hospital's prior year cost per DRG as the basis for establishing initial propsective rates.

As an overview to this issue, it should be noted that HHS, in proposing its prospective payment system, is primarily concerned about the rate of growth in hospital costs. In its fact sheet supporting its proposal, HHS offers 8 specific statements as to why there is a need for Congress to take action:

"In 1982, health care costs went up almost three times the national inflation rate.

"The cost of health insurance rose 15.9 percent last year, the biggest increase ever.

"High health inflation is a long-term trend. Since 1965, consumer prices have risen two and a half times while hospital costs have shot up five and a half times.

"Health care costs are consuming a growing portion of the nation's output: 10.5 percent of GNP in 1982, compared with 5.9 percent in 1965.

"The cost of the average hospital stay jumped from $316 in 1965 to $1,844 in 1980.

"American taxpayers (through Medicare and Medicaid) pay a large part of those costs: 40 percent of all hospital bills.

"This year, Medicare and Medicaid will spend as much every month as they did during the entire year of 1966, their first full year of operation.

"Over the last five years, Medicare costs have *increased* an average annual rate of 19 percent." [Emphasis added.]

Clearly, the identified problem is the rate of growth in hospital's expenditures.

While both a prospective payment system based upon "national averages" or "hospital specific" rates can be used to control the rate of growth in expenditures, the use of the "national average" also serves to redistribute exsiting medicare expenditures. Conceptually, HHS currently is collectively paying hospitals at the national average. It pays some hospitals above the average and others below. In total, however, HHS ends up paying at the average. By paying every individual hospital the national average, HHS is merely redistributing existing medicare dollars before it begins the process of controlling the growth of future expenditures. Some hospitals would receive immediate windfalls while others would be devastated.

Before authorizing such a potentially massive redistribution of dollars, Congress must assure itself that its redistribution methodology is equitable. Over the years, hospitals throughout this country have developed expenditure levels based upon a series of social, economic, political and medical reasons. To now ignore these historical pressures and instead substitute a national redistribution system would be a serious mistake.

As a redistribution system, we believe the HHS proposal has major flaws.

First, we believe the DRG as a unit of measure may not accurately account for severity differences among hospitals. Secretary Schweiker's report to Congress indicates that:

"Severity within DRG is primarily a concern if certain hospitals tend to have more severe cases within DRGs compared to other hospitals, and if severity is positively associated with costs.

"*HCFA is planning to examine the extent to which certain groups of hospitals treat more costly patients within DRGs.*" [Emphasis added.]

We would suggest that this is a critical issue that should be examined before this DRG redistribution system is enacted. (Given the extensive data bases that exist in the rate regulated states, would suggest that HHS look to these states for assistance in addressing this issue.) If national payment rates are to be established, it is important to insure that hospitals that have traditionally treated severely ill patients are differentiated from hospitals that provide care to less critically ill patients. Preliminary data that we have reviewed (Horn, et al., 1981) indicates that significant severity differences do in fact exist within DRG's among hospitals.

Second, the proposal incorporates an adjustment to "standardize case costs for difference in . . . wages across hospitals." Since labor represents approximately 60 percent of any hospital's costs, this is a very critical adjustment. As pointed out in the testimony presented today by Harold Cohen, executive director of Maryland's Health Services Cost Review Commission, this adjustment is seriously flawed. In our State for example, church hospital, which is an inner-Baltimore city hospital would receive the same wage factor as Carroll County General Hospital, which is a community hospital located in Carroll County, a quasi-rural area of Maryland.

Further, physicians memorial hospital, a 112 bed hospital in La Plata, Maryland, would receive a age factor 20 percent higher than Calvert Memorial Hospital, a 111 bed hospital located in Calvert County, Maryland, approximately 30 miles from Physicians Memorial.

Clearly, anyone familiar with Maryland labor markets realizes that Church Hospital and Carroll County General Hospital are not in the same labor market and Physicians Memorial and Calvert Memorial should not have a 20 percent wage factor variance. Yet, the HHS proposal makes these determinations.

Finally, the Secretary has indicated that: "Since the Department does not wish to reduce beneficiary access to care or to encourage hospitals to withdraw from the program, the Department's plan includes a policy for outliers which provides equity to providers and to beneficiaries, but does not undermine the integrity of the prospective payment system."

Further, while estimating that only one half to 1 percent of cases are outliers, the Secretary indicates that: "The actual percentage to be identified as outliers *will be determined* after careful review of the available data." [Emphasis added.]

Based on Maryland's experience, as well as I believe the experience in new Jersey, the number of true outliers (i.e., cases that are not clinically coherent and homogeneous with respect to resource use), will be extensive. Would, therefore, suggest that absent a study of the outlier issue, national average DRG rates should not be implemented.

In summary, we would argue that the use of national DRG averages is clearly a flawed mechanism for redistributing medicare dollars. Instead, we believe that the AHA approach of establishing the initial year's prices based on individual hospital's prior year cost per DRG is more rationale than using a national average hospital cost per DRG as proposed by HHS.

The AHA proposal responds to the government's need to control the growth of hospital expenditures by creating positive incentives for hospitals to control unit prices and resource utilization while protecting against the types of inappropriate windfall profits or catastrophic losses that can result from the use of a national average cost per DRG that fails to adequately adjust for patient severity and local labor market differences among hospitals.

U.S. COMMUNITY HOSPITALS, 1975–80: PERCENT INCREASE IN EXPENSE PER ADJUSTED ADMISSION

Rank and State	Cumulative increase	Annual increase
1—Alaska	149.67	20.08
2—District of Columbia	123.12	17.41
3—Nevada	111.88	16.20
4—New Mexico	111.71	16.18
5—Montana	109.36	15.93
6—Wyoming	108.14	15.79
7—Hawaii	107.54	15.72
8—Utah	104.99	15.44
9—Kansas	100.13	14.88
10—North Dakota	97.30	14.56
11—Colorado	96.97	14.52
12—South Dakota	96.18	14.43
13—Maine	96.08	14.42
14—California	95.23	14.32
15—Oklahoma	96.57	14.24
16—Missouri	93.22	14.08
17—Idaho	92.37	13.98
18—Arkansas	90.78	13.79
19—Illinois	90.13	13.71
20—Iowa	90.00	13.70
21—West Virginia	89.81	13.67
22—Oregon	89.34	13.62
23—Texas	88.20	13.48
24—Virginia	88.04	13.46
25—Wisconsin	87.93	[1] 13.45
26—Alabama	87.73	13.42
27—Ohio	86.57	13.28
28—Minnesota	85.14	13.11
29—South Carolina	84.52	13.03

U.S. COMMUNITY HOSPITALS, 1975–80: PERCENT INCREASE IN EXPENSE PER ADJUSTED ADMISSION—Continued

Rank and State	Cumulative increase	Annual increase
30—Pennsylvania	84.48	13.03
31—Louisiana	83.95	12.96
32—Indiana	83.92	12.96
33—Tennessee	83.80	12.95
34—Mississippi	83.42	12.90
35—North Carolina	82.60	12.80
36—Kentucky	82.02	12.73
37—Arizona	80.69	12.56
38—New Hampshire	78.69	12.31
39—Washington	78.02	[1] 12.23
40—Florida	77.98	12.22
41—Georgia	77.49	12.16
42—Michigan	76.91	12.09
43—Nebraska	74.47	11.77
44—Massachusetts	72.41	[1] 11.51
45—New Jersey	68.22	[1] 10.96
46—Delaware	67.56	10.87
47—Rhode Island	67.42	[1] 10.86
48—Maryland	67.23	[1] 10.83
49—Connecticut	65.51	[1] 10.60
50—Vermont	63.14	10.28
51—New York	51.62	[1] 8.68
U.S. Average	79.60	12.42
Mandatory	61.83	10.1
Non-mandatory	86.59	13.29

[1] Those programs which require hospitals both to participate and comply.

STATEMENT OF ROBERT M. CRANE, DIRECTOR, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH

Mr. CRANE. Mr. Chairman, I am Robert M. Crane, director of New York State's office of health systems management. In New York State we have had a cost containment system for the past decade. January 1 we started an all-payor system under a medicare waiver recently approved by the Department. My testimony outlines some of the aspects related to diagnostic-related groups that we have considered in New York State, some of the ways in which we modify our rate of payment based on case mix factors which we believe are essential to any prospective payment system.

I won't go into those, since they are covered in detail in my prepared statement.

What I would like to do is highlight four issues which I believe the committee should consider in developing its final recommendation.

First as has been mentioned by other speakers, an all-payor cost containment system should be considered as an alternative to a medicare-only system. Recognizing the jurisdictional issues that Mr. Moore raised earlier, our own experience in New York State has led us to the conclusion that an effective cost containment system requires that all payors participate. Otherwise the primary effect is cost shifting.

In New York State we started with a medicaid and Blue Cross cost containment system. We found that charges for the commercial insurers and private paying patients increased to a point where in some hospitals there is between a 25- and 80-percent difference between charges and costs. I think we can probably agree that what is desirable in any prospective system is a change in hospital behavior, and without an all-payor system our concern is that the behavior goes, as Mr. Cohen indicated, to creative accounting as opposed to cost reduction.

Second, States should be encouraged to adopt all-payor systems and continue experimenting with new methodologies. The Department of Health and Human Services now discourages this. Certainly States which have demonstrated cost savings in the past should not have that experience held against them, as has been the recent case with both Massachusetts and New York. In both cases, HCFA granted statewide waivers that their medicare costs be kept 1.5 percent below the national rate of increase.

Presumably this was the price of choosing a State all-payor system versus the national medicare only for DRG cost containment system. The reverse should be true. An incentive should be developed for States to move in this direction. We would recommend that legislation that the committee adopts should require State systems to perform as well as the Nation but prohibit the Department from requiring a more rigorous performance standard.

Third, a strong system of utilization review should be developed concurrently with the prospective rate system. The old addage goes "you get what you pay for." Under a system which pays hospitals on a per day basis, there is an incentive to increase days. Our concern with the proposal before you is that admissions will increase. A strong utilization review program is essential to deal with this.

Finally, any prospective reimbursement system adopted should be completed by a strong system of health planning. The administration's proposal contains a pass-through of capital while at the same time advocating the repeal of the health planning program. The prospective payments system proposed will do little to moderate rising capital costs, and in fact may encourage unnecessary capital expenditures to give hospitals competitive advantages under the DRG system.

New York is a strong advocate of a strong health planning program at the State and local level. We are seeing major increases in proposed capital expenditures, some of which are surely needed. Yet approval of all these expenditures lies in a realm well beyond what we can afford. Impact from projects that New York State currently has in front of it if approved would have an impact on the medicare program of approximately $6 billion over their useful lives. As the committee considers the cost containment system for medicare, an improved system of health planning should also be considered.

The planning process such as that envisioned in section 1122 of the Social Security Act should be mandated so that capital is part of any system that is put into place.

Thank you, Mr. Chairman.

Chairman JACOBS. Thank you, Mr. Crane.

[The prepared statement follows:]

STATEMENT OF ROBERT M. CRANE, DIRECTOR, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH

SUMMARY

Over the past decade the development of a prospective hospital payment system has placed New York State in a leadership position in restraining hospital costs. In January 1983 this payment system was extended to all payors including Medicare under a waiver approved by the Health Care Financing Administration (HCFA). New York pays hospitals on the basis of an all-inclusive per diem rate not on a diagnostic related group (DRG) per case basis as is proposed by the Department of Health and Human Services. However, diagnostic related groups and the related major diagnostic categories play a major part in the methodology. New York establishes each hospital's case mix intensity which is used in three different ways to determine the hospital's rate under the New York system.

First, DRG based case mix data are used to cluster hospitals into comparable groups for the purpose of establishing operational cost standards. Second, each hospital's DRG complexity relative to its peers is used to determine its individual allowable cost per day. Finally, the length of stay standards applied to hospital costs are corrected for a facility's mix of patients' types.

New York is aware of the shortcomings of a per diem reimbursement methodology. The most notable shortcoming is the incentive it provides to prolong patient length of stay. Nonetheless, after careful consideration New York chose not to reimburse facilities based on diagnostic related groups for several reasons.

First, a number of factors undermine the accuracy of the DRG structure. These include faulty reporting by hospitals and other data base problems, uncertainty between principal and secondary diagnosis, lack of socio-economic factors influencing health status, and the use of average length of stay as the proxy resource consumption.

Second, in our case mix study we encountered difficulty in DRG costing because of the non-comparability of hospital cost allocation, the difficulty in isolating teaching costs and the lack of unformity in hospital reporting.

It is clear that some of these problems can be overcome and that there are attendant problems with any reimbursement scheme. Similarly there are incentive problems with a DRG per case reimbursement system such as the incentive to increase admissions, the incentive to avoid cases that require exceptional treatment patterns and the now well-known phenomenon of "DRG creep" which the Committee will need to examine and design mechanisms to overcome.

Independent of the type of prospective system that is adopted, I would urge the committee to also consider the following:

First, an all-payor cost containment system should be considered as an alternative to a Medicare-only system. Our own experience in New York State, in fact, led us to conclude that an effective cost containment program requires that all payors participate. Otherwise, the primary effect is simply cost shifting among third-party payors. We started with a system for Medicaid and Blue Cross only and found that hospitals rapidly raised charges to private payors to a point where in some institutions charges are between 25–80 percent above cost. The net result of allowing hospitals to allocate their costs from Medicare to other payors also reduces the impact of cost containment to Medicare. That is, the focus is on reallocating the same costs rather than on more effective and efficient management of hospital resources. At the extreme it may also offset the availability of adequate services to Medicare patients.

Second, states should be encouraged to adopt all-payor systems and continue experimenting with payment methodologies. The Department of Health and Human Services now discourages this. Certainly states which have demonstrated cost savings in the past should not have this experience held against them as has been the recent case with Massachusetts and New York. In both cases, HCFA has granted statewide waivers with the condition that their Medicare costs be kept 1.5 percent below the national rate of increase. Presumably, this was the "price" of choosing a state all-payor system versus the national Medicare-only or DRG based system of cost containment. In fact, the reverse should hold. The liabilities of a single-payor system instead should push the scales in favor of implementation by states of their own comprehensive programs. Requiring states to maintain Medicare costs at levels below, as opposed to at, the national average simply erodes provider support for these state alternatives. Such below-average Medicare caps imposed by HCFA along with the recently announced HCFA policy that all new state systems must use a DRG form of payment discourage all-payor systems and continued state experimentation since the Medicare-only program allows hospitals to avoid the risks of receiving less than they would have under the national system as well as to reap the benefits of cost shifting.

Finally, any prospective reimbursement system adopted should be complemented by a strong system of health planning. The Administration's proposal contains a "pass through" of capital costs while at the same time advocating the repeal of the health planning program.

The prospective payment system proposed will do little to moderate rising capital costs and, in fact, may encourage unnecessary capital expenditures to give hospitals competitive advantages under a DRG system.

New York is a strong advocate of a rational and aggressive health planning system at the local and state level as a complement to its prospective payment system.

As the Committee considers a cost containment system for Medicare, an improved system of health planning should also be considered. A planning process such as that envisioned in Section 1122 of the Social Security Act should be mandated so that capital is a part of the cost containment system that is put in place.

STATEMENT

Mr. Chairman, distinguished members of the Committee, I am Robert M. Crane, Director of the New York State Office of Health Systems Management. I appreciate the opportunity to testify before you today because we in New York have been pioneering case mix efforts with diagnostic related groups (DRGs) since 1977. While New York State does not pay hospitals using a DRG per case reimbursement system, case mix measures have been an integral component of our hospital payment system for a number of years.

In December of 1977, the Health Care Financing Administration (HCFA) funded New York's Case Mix Study, a research project involving a representative sample of forty-one hospitals throughout New York State which had as its purpose the development of a methodology to measure the relationship between case mix and hospital costs. The choice of New York as a research and demonstration site was and is particularly relevant to the national hospital system:

New York's 290 hospitals range in size from 20-bed community hospitals in isolated rural communities to 1,000-bed urban medical centers serving patients from all over the world. Yearly budgets exceed the gross national product of some nations.

In New York, voluntary hospitals account for 75 percent of total hospital beds, proprietary hospitals 8 percent, and public hospitals 17 percent. Nationally, voluntary hospitals account for 70 percent of all hospital beds, proprietary hospitals 8 percent, and public hospitals 22 percent.

New York has 3.9 beds per 1,000 population; nationally this figure is 4.5 beds per 1,000 population.

Indeed, New York's hospital industry not only mirrors the variety and the problems of hospitals throughout the nation, it also represents a major component of our country's medical resources: New York has 8 percent of the nation's hospital beds. New York's hospitals employ more than 10 percent of the nation's hospital workers. Hospital expenditures in New York account for 10 percent of the nation's hospital expenditures and a similar or greater percent of Medicare's expenditures for hospital care. New York has 15 percent of all teaching hospitals in the nation.

Finally, New York has been no stranger to the problems now confronting the nation—ensuring that quality health care services are provided to our citizens at a reasonable cost. Our State has been committed to a vigorous and successful cost containment program since the late-60's. As noted in the Department of Health and Human Services' December 1982 Report to Congress on Hospital Prospective Payment for Medicare, New York has had the best record of any State in the Nation in restraining hospital costs. Between 1975 and 1979, total hospital costs in this country increased by 64.5 percent while New York's hospitals increased at less than half that rate, 31 percent. Looking at a later period, 1977-1981, the national annual percent increases in cost per adjusted admissions averaged 13 percent. During that same period, costs in New York increased by only 9.78 percent. The application of case mix data to our cost containment efforts since 1976 has added credibility and ensured that the outcome has been reasonable and responsive to providers.

A prospective cost-based reimbursement formula for hospitals was first implemented in New York in 1969. Over the years we have evolved a payment program that has gone beyond that basic notion of merely containing inflation rates to one that incorporates financial incentives and controls aimed at three principles: Cost containment measures should not adversely affect actual patient care programs;

payment should be based only on care that is efficiently provided; and unnecessary services must be eliminated, or, at the very least, sharply reduced.

Until the past year the Public Health Law in New York required hospitals to be paid at rates related to the "efficient production of services". These efficiency standards have been defined by hospital peer group standards which, in turn, have evolved to a high degree of technical sophistication. By the mid-1970's both the State and the industry recognized that these standards must be applied to comparable hospital products. That is, the cost efficiency standards and norms must be adjusted for an institution's particular mix of patients.

The units of cost most frequently selected or cost comparisons are patient days and admissions. Neither of these units offer uniform measurement; changes in the type of care delivered and the severity of patient types admitted may have important consequences for hospital care.

A shared recognition of the need to explore the relationship between hospital costs, patient diagnoses and hospital patterns of treatment stimulated a cooperative effort between the New York State Department of Health and the Hospital Association of New York State that resulted in the federally funded Case Mix Study. We began applying by-products from the Study as early as 1978 to hospital reimbursement rates. In fact, case mix indices were used to adjust reimbursement appeals dating back to 1976. Since 1981 case mix or service intensity weights have been directly incorporated into hospital rates.

We are quite familiar with the advantages of paying hospitals according to an entire episode of care. DRG reimbursement can (i) reverse the incentive to prolong length of stays that are prevalent under a per diem system; (ii) reimburse the reasonable, total cost of a hospital stay while discouraging the provision of unnecessary ancillary services as in a system linked to charges; and (iii) reflect the resource requirements due to the specific mix of patients in a hospital.

Despite these merits, we in New York chose an alternative route as a result of the research from the Case Mix Study and a review of the pros and cons of the DRG rate system—both activities carried out in conjunction with the hospital industry.

In New York State we reimburse hospitals on the basis of an all-inclusive per diem rate. Because of the size and complexity of New York's health care system we use a formula-based methodology rather than a time-consuming budget review process.

New York has adopted the principle that the best way to measure a hospital's efficiency is to compare it to its peers. We developed a grouping methodology to compare similar hospitals using a variety of factors such as size, location, teaching versus non-teaching, average age of the hospital patients, case mix, and so on. We established reimbursement ceilings at slightly above the average routine and ancillary cost for each group—with facility-specific case mix adjustments. In effect, this establishes the average cost as our basic standard of the efficient production of services. However, we permit any hospital with costs exceeding this standard to appeal based on a variety of factors.

We refined this system which has an incentive to lengthen stays by incorporating a system for disallowing the unnecessary cost of excessive patient length of stays. We also included in our rate methodology a system for disallowing the unnecessary costs incurred by hospitals with chronically low occupancy. Empty beds and expensive equipment lying unused for a large part of each day is another common cause of high unit costs and without a doubt, one of the least defensible. We developed a schedule of minimum utilization standards that took, into account the type of service, e.g., medical/surgical, obstetric, and open heart surgery. Provisions are made for the special circumstances of isolated rural hospitals.

Hospitals are not reimbursed for the extra per diem cost when occupancy falls below these standards. This provision was not only effective in reducing expenditures, but it provided an incentive for consolidations, mergers, and closures.

A volume adjustment which is related to fixed and variable costs is used to reward hospitals for reducing patient hospitals days. We reimburse any hospital able to reduce patient days below predetermined target approximately 80 percent of its per diem rate of payment for every day of care below the target that the hospital did not provide. Conversely, we reimburse any hospital unable to control patient days only 20 percent of its per diem rate of payment for every day of care provided above this target.

Each hospital's individual case mix intensity is used three ways in determining its rate under the New York system. First, DRG based case mix data are used to cluster hospitals into comparable groups for the purpose of establishing operational cost standards. Second, each hospital's DRG complexity relative to its peer groups is then used to determine its individual allowable cost per day. Finally, the length of stay standards applied to hospital costs are corrected for a facility's mix of patient types. These same case mix standards apply under the recently approved all-payor system in New York.

These adjustments produce hospital rates which are essentially equivalent to DRG rates and overcome the inherent problems normally associated with per diem payments. On the other hand, using the case mix measures as adjustments to an all-inclusive rate overcomes many of the imprecision problems of the DRG specific rate such as classifying unusual cases and accurately pricing out diagnoses and is less likely to encourage "DRG creep" since hospital income in not as directly related to billed diagnosis.

Unfortunately, a number of factors undermine the accuracy of the DRG structure: Faulty reporting by hospitals; confusion between principal and secondary diagnoses; lack of socio-economic factors influencing health status; and the use of average length of stay as a proxy for resource consumption.

The flaws of the DRG system itself are then compounded by the imprecisions of DRG costing such as: Non-comparability of hospital cost allocation; difficulty in isolating teaching costs; and nonuniformity in hospital reporting.

The result is a DRG "cost standard" subject to attack and difficult to defend as an absolute dollar value. However, these imprecision problems can be better tolerated or at least diffused when DRG intensity weights are used instead. Thus, in New York we felt that even within the context of these limitations the DRG patient grouping is an effective tool. It certainly is an acceptable means by which to measure the relative case mix complexity of hospitals. By this I mean that even the most refined index will have shortcomings: We will always have reporting errors; we will never be able to adequately describe all patients to everyone's satisfaction; we can never hope to account for all hospital differences; and we will never be able to precisely price out the cost of each case.

This is not meant to denigrate the DRG system; it simply reflects the fact that no system is without problems. In a world of close approximation, these case mix measurements certainly more than fit the bill. They represent a major step forward in manageable way; they have been sufficient for our purpose of relative complexity measures, not an objective number but as a measure relative to other institutions in the hospital system.

Of course, before completely abandoning the per diem system, the federal government must also ask itself what new problems this unit of payment by DRG may present. For example:

Hospitals may increase their admission rates. Commenting on the payment for patient days, it has been said that "you get what you pay for". Similarly, payment for cases could well encourage a greater turnover of patients and admissions of cases that might otherwise be treated as outpatient. Therefore, admissions review and certification become important utilization review functions as has been recognized.

Hospitals may not be sufficiently reimbursed for aberrant cases. There are always patients representing exceptional treatment patterns whose status requires a greater amount of services than those normally accounted for under any average case payment. Such events are inevitable and some accommodation must be made either on an exception basis or built into the reimbursement system.

Under DRG payment there is likely to be a tendency for hospital staff to "over-report" the characteristics of their patient load. Since more complex cases result in higher payments, there is an incentive to provide a more detailed picture of patient mix. In fact, there is likely to be a general rise in the complexity rating of all hospitals to generate more income. It is interesting to note that because of age a substantial portion of Medicare patient cases are assumed to fall into complex diagnoses.

Although I have raised some of the incentive problems with DRG payments, none of these is really insurmountable. Rather, the single, most important dilemma facing the proposed federal system is not DRGs but the issue of a Medicare-only prospective system.

Our own experience in New York State, in fact, led us to conclude that an effective cost containment program requires that all payors participate. Otherwise, the primary effect is simply cost shifting among third/party payors. We started with a system for Medicaid and Blue Cross only and found that hospitals rapidly raised charges to private payors to a point where in some institutions charges are between 25–80 percent above cost. The net result of allowing hospitals to allocate costs from Medicare to other payors also reduces the impact of cost containment to Medicare. That is, the focus is on reallocating the same costs rather than on more effective and efficient management of hospital resources. At the extreme it may also offset the availability of adequate services to Medicare patients.

I raise this issue not to discourage the pursuit of a federal cost containment program. To the contrary, there is a dire need to balance the demand for essential health services with fiscal and economic realities. However, given the concern with the impact of cost shifting—that it does not reduce the total health care cost to the public and undercuts the intended incentives for more cost efficient services—there should be more stress concurrently on fostering all-payor systems by the states.

Certainly the intent of provisions of the Tax Equity and Fiscal Responsibility Act was to encourage the approval of more state waivers for comprehensive cost containment programs. Given the drawbacks of a Medicare-only system and the problems noted with a DRG payment system, I would strongly recommend that states be encouraged to continue the experimentation with all-payor systems using different methods of payment so that our learning process can continue. Certainly states which have demonstrated cost savings in the past should not have this experience held against them as has been the recent case with Massachusetts and New York. In both cases, HCFA has granted statewide waivers with the condition that their Medicare costs be kept 1.5 percent below the national rate of increase. Presumably, this was the "price" of choosing a state all-payor system versus the national Medicare-only or DRG based system of cost containment. In fact, the reverse should hold. The liabilities of a single-payor system instead should push the scales in favor of implementation by states of their own comprehensive programs. Requiring states to maintain Medicare costs at levels below as opposed to at the national average simply erodes provider support for these state alternatives. Such below average Medicare caps imposed by HCFA and the recently announced HCFA policy that all new state systems must use a DRG form of payment discourage all-payor systems and continued State experimentation since the Medicare-only program allows hospitals to avoid the risks of receiving less than they would have under the national system as well as to reap the benefits of cost shifting.

Another provision of the Administration's proposal that is of great concern relates to the "pass through" of capital costs while at the same time advocating the repeal of the health planning program.

The prospective payment system proposed will do nothing to moderate capital costs and, in fact, may encourage unnecessary capital expenditures to give hospitals competitive advantages under a DRG system.

New York is a strong advocate of a rational and aggressive health planning system at the local and state level as a complement to its prospective payment system.

In 1965, New York began the nation's first certificate of need program. Our health planning program has become an effective complement to our cost containment programs. Since 1975 and through these programs, we have removed over 12,000 excess beds from our hospital system, increased the efficient use of our remaining beds, and encouraged the development of alternative model of care. However, we are now facing a new problem—one which other states will also face and which has the potential of restarting the cycle of escalating costs, forcing increased taxes, and increases in employee health insurance costs.

The scope of the problem quickly becomes evident when we look at the statistics on the total dollar amounts of capital construction in health care approved by New York State over the last few years. In 1979, the State approved $236 million in new projects and $369 million was sanctioned in 1980. In the last two years capital projects with initial cost estimates of $815 million received State approval. This year we are faced with projects totalling nearly $3 billion and by 1984 that figure will exceed $5 billion. This figure is well in exceed $5 billion. This figure is well in excess of anything which we consider reasonable or acceptable in an era of limited and contracting resources.

By some estimates, the total capital costs including interest costs could be $10 to $15 billion. The cost to the federal Medicare program could be $6 billion.

New York is currently considering major changes in its certificate of need program to deal with this problem by adding the concept of relative need and affordability. Governor Cuomo has proposed a new capital budgeting process for hospitals and other health care facilities that will add discipline to this process. This will be developed during 1983.

As the Committee considers a cost containment system for Medicare, an improved system of health planning should also be considered. A planning process such as that envisioned in Section 1122 of the Social Security Act should be mandated so that capital is a part of the cost containment system that is put in place.

In closing, I only wish to encourage this Committee to build upon the lessons that we have learned in New York. Prospective reimbursement which employs DRGs for Medicare represents a major step towards an effective and equitable cost containment program. However, it is not enough. Hospitals are likely to continue to avoid hard management decisions by merely shifting costs to non-Medicare patients. States should be encouraged to be more aggressive in the designing of cost containment systems which best meet their needs and environments. This might build upon competitive approaches or the public utility model or some blend of these approaches. States given the proper incentives and encouragement can help solve the cost containment problem by further refining or creating programs that apply cost containment principles to all third-party payors. Such programs can be designed to recognize unique hospital problems and can be closely tied in a synergistic manner to health planning, utilization review, and other state-run programs. In short, the Congress as part of its consideration of a national cost containment program for Medicare should encourage the growth of cost containment systems by states which support and even strengthen national hospital cost containment goals.

Chairman Jacobs. Representing the New Jersey Department of Health, Faith Goldschmidt.

STATEMENT OF FAITH GOLDSCHMIDT, RESEARCH SPECIALIST, ON BEHALF OF CHARLES F. PIERCE, JR., DEPUTY COMMISSIONER, NEW JERSEY DEPARTMENT OF HEALTH

Mr. Goldschmidt. I am Faith Goldschmidt, health research specialist with the New Jersey State Department of Health DRG project. I am here on behalf of Charles Pierce, the deputy commissioner of health.

New Jersey acute care general hospitals instituted the diagnosis related group [DRG] system as a means of hospital reimbursement for all patients in 1980.

Our hospitals were phased in over a 3-year period and all had implemented DRG as of December 1, 1982.

We feel that the DRG system has the following benefits:

One, it is a clinically based system. The allocation of resources is equitable and based on a specific product—a DRG. Each hospital is reimbursed according to the complexity and volume of the cases it treats, not according to a fixed rate per day that ignores the casemix experience of that hospital.

Two, hospitals and physicians are encouraged to use resources in an efficient manner by focusing on the DRG as the product plus the use of payment incentives for efficiencies and disincentives for inefficiencies according to each cost element. By using a variety of reports, hospital management can and does work with physicians to more effectively and efficiently manage their patients.

Three, in New Jersey there is equity across all payors. All payors pay the DRG payment rate for inlier patients. Therefore the massive cost shifting that occurs elsewhere in the country to cover discounts and uncompensated care does not occur in New Jersey.

Four, uncompensated care which includes primarily indigent care is one of the hospital's financial elements in New Jersey. By including uncompensated care in the hospitals elements of cost, well-managed inner-city hospitals can concentrate on effectively providing quality care for patients regardless of social or economic status.

Information on the following points might be of interest to the committee.

No. 1, DRG construction. The 470 DRG's used were constructed by Yale and the National Steering Committee. There was a great deal of clinical input into these DRG's, and they are meaningful both in the clinical and financial sense. In addition, New Jersey uses seven categories to describe patients atypical in length of stay or resource consumption.

These patients are outliers and they are billed charges. New Jersey has about a third of its hospital patients as outliers.

No. 2, data requirements. There must be extensive computer capability for the hospital, the fiscal intermediary and for those who set the rates. There must be the ability to check and correct DRG assignments and claims and generate and interpret reports.

No. 3, implementation. Based upon New Jersey's experience the phasing-in over a 3-year period of New Jersey hospitals was very important. It is not until a system is in place that many of the problems will be discovered.

No. 4, education. We feel there is a great need for education about the system at all levels—at the regulator level, payors, hospitals, physicians, and patients.

No. 5, independent monitoring. There is also a need for independent monitoring to insure that quality of care does not deteriorate because of the incentives to reduce expenditures. There is no evidence in New Jersey that the DRG system has had a negative impact on the quality of care.

No. 6, new technology. New technology and procedures are addressed in New Jersey by the Rate Setting Commission itself through a specific clinical appeal mechanism or the certificate of need process.

No. 7, flexiblity. Allowance should be made for States to have the flexibliity to implement their own systems provided such systems will meet the Federal objectives of cost containment. Of particular importance is to allow these States that are inclined to incorporate all payors to minimize cost shifting to do so.

We have found that local level management is extremely important in fostering cooperation within the industry. Local management allows rapid response in the identification of problems, in information gathering, solutions, and implementation of the solutions.

Thank you.

[The prepared statement follows:]

STATEMENT OF CHARLES F. PIERCE, JR., DEPUTY COMMISSIONER, NEW JERSEY STATE DEPARTMENT OF HEALTH

SUMMARY

Mr. Chairman, members of the committee, my name is Charles Pierce. I am Deputy Commissioner of the New Jersey State Department of Health. With me are Joseph Morris, acting Assistant Commissioner and Faith Goldschmidt, Health Economics Research Specialist I.

New Jersey acute care general hospitals instituted the Diagnosis Related Group (DRG) System as a means of hospital reimbursement for all patients in 1980.

Our hospitals were phased in over a three year period and all had implemented DRG as of December 1, 1982.

We feel that the DRG System has the following benefits:

1. It is a clinically based system. The allocation of resources is equitable and based on a specific product—a DRG. Each hospital is reimbursed according to the complexity and volume of the cases it treats, not according to a fixed rate per day that ignores the case-mix experience of that hospital.

2. Hospitals and physicians are encouraged to use resources in an efficient manner by focusing on the DRG as the product plus the use of payment incentives for efficiencies and disincentives for inefficiencies according to each cost element.

The DRG system provides valuable information for the hospital's management to communicate with its medical staff. The physician is the resource consumer, because he or she admits the patient, orders all services and discharges the patient. Using a variety of reports, hospital management can and does work with physicians to more effectively and efficiently manage their patients.

3. In New Jersey, there is equity across all payers. Therefore, the massive cost shifting that occurs elsewhere in the country to cover discounts and uncompensated care, does not occur in New Jersey.

4. Uncompensated care, which primarily includes indigent care, is one of the hospital's financial elements. By including uncompensated care as an element of cost, well managed inner city hospitals can concentrate on effectively providing quality medical care to all patients regardless of social or economic status.

Information on the following topics was specifically requested by the Subcommittee:

1. DRG Construction.—The 467 DRGs used were constructed by Yale University and the National Steering Committee. There was a great deal of clinical input into the new DRGS, and they are meaningful both in the clinical and financial sense. New Jersey uses 7 categories to describe patients atypical in length of stay or resources consumption. These patients are "outliers" and are billed charges.

2. Data Requirements.—There must be extensive computer capability for the hospital, the fiscal intermediary and for those who set the rates. There must also be the ability to check and correct DRG assignment and claims, and generate and interpret reports. Data submissions must contain accurate data and be timely.

3. Implementation.—Based upon New Jersey's experience the phasing-in the hospitals over a three year period was very important. It is not until a system is actually in place and being used, that many of the problems will be discovered.

4. Education.—There is great need for education about the system at all levels—regulations, payors, hospitals, physicians, and patients.

5. Independent Monitoring.—There also is need for an independent monitoring system to ensure that quality of care does not deteriorate because of the incentives to reduce expenditures. There is no evidence in New Jersey that DRGs have had any negative impacts on the quality of care.

6. New Technology.—New technology and procedures are addressed in New Jersey by the Rate Setting Commission, either by a specific clinical appeals or by the Certificate of Need system. Periodically, rebasing the system also will help incorporate the advances in medical practice.

7. Flexibility.—Allowance should be made for states to have the flexibility to implement their own systems, provided such systems will meet the Federal objectives of cost containment. Of particular importance is to allow these states that are inclined to incorporate all payers to minimize cost shifting to do so.

You and your colleagues on this committee are faced with an enormous task, one on which the future well-being of literally millions of Americans will depend. In this age of dwindling health resources, it is imperative that health care services be provided in the most efficient and effective manner possible. But cost containment efforts, if undertaken in haste and without adequate foresight, can substantially impair the ability of many of our sickest and most truly needy citizens to receive vitally necessary health services, and substantially damage, if not destroy, many of our most valued social institutions, such as urban hospitals, medical school teaching hospitals, and certainly public hospitals, as well as some rural hospitals that serve many of the poor.

Since there is a need to reduce the costs of health programs, you can do so either by reducing services or by reducing the payment for each unit of service.

We are beginning to learn in New Jersey, as has been previously demonstrated in Maryland, that well-conceived state programs to regulate hospital costs can effect considerable savings. Such programs are being implemented without serious restrictions on the availability of service or the financial viability of the providers of care, and indeed can even do much to improve the financial status of well-managed institutions which serve a disproportionately large number of poor citizens. The evidence on controlling the rate of increases in prices in the hospital sector in those states with mandatory cost containment programs is clear and encouraging. (See Attachment A).

New Jersey is one of those states with a mandatory cost containment program in place. A budget review per deim system (Standard Hospital and Rate Evaluation) went into effect in 1975. At the outset we believed that to contain hospital costs, it was necessary to reach the true resource consumer, the physician. Thus, the system had to be clincial in nature and take into account the differences in hospital casemix. In 1976 work began on developing a prospective payment system based on Diagnosis Related Groups (DRGs). In 1980, twenty-six of New Jersey's acute care general hospitals implemented the DRG system. In 1981, thirty-five more implemented and by December 1, 1982, all 99 acute care general hospitals in New Jersey had implemented DRGs.

The heart of the New Jersey system is the ability of the Department of Health to actually calculate the cost of treating patients for a specific illness and treatment. The patient's bills, medical discharge abstracts and the hospital cost reports are used to calculate a direct patient care portion of the rate for each DRG. The direct patient care portion (which are those services such as nursing and ancillary services and medical supplies) is adjusted by factors for labor market area, urban-rural setting and teaching status. A hospital specific mark-up factor is applied to the direct patient care portion to cover the hospital's indirect costs (which are those costs such as the debt service costs and administrative overhead). At the time of hospital billing of a DRG, a payer factor, which covers a portion of the hospital's indigent care costs, is applied.

In summary, a patient in New Jersey is billed: Direct patient care rate times mark-up factor times payer factor equals total bill (DRG payment rate). The DRG payment rate is the average amount of resources consumed in a hospital to treat a patient within a given DRG.

We feel that the DRG system has the following benefits:

(1) It is a clinically based system. The resources consumed are equitably distributed and based on specific procedures—DRGs. Hospital are reimbursed according to their case mix and the volume of each case, not by the number of patient days. The 467 DRGs reflect the range if illnesses and injuries among the patients and the DRGs are meaningful clinically and financially.

(2) Hospitals are encouraged to use resources in an efficient manner. There is an incentive for hospitals to decrease expenditures through more effective clincial and financial management. This encourages dialogue among the administration, medical staff and hospital departments to determine how to manage more effectively. The system is prospective so hospitals will know their revenues in advance and can plan their expenditures accordingly.

(3) In New Jersey, there is equity across all payers. Therefore, the massive cost shifting that occurs elsewhere in the country to cover discounts and uncompensated care does not occur in New Jersey.

(4) Uncompensated care, which primarily includes indigent care, is one of the hospital's financial elements. By including uncompensated care as an element of cost, well managed inner city hospitals can concentrate on effectively providing quality medical care to all patients regardless of social or economic status.

DRG CONSTRUCTION

A. Basic construction

The DRGs used in New Jersey are the set of 467 DRGs developed by Yale University. Yale set up a National Steering Committee in 1979, and over the next two years the committee constructed a new set of DRGs, based directly on International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) codes.

A numeric code for every diagnosis and procedure is contained in three ICD-9-CM volumes. Every patient who is admitted to a hospital has a PRINCIPAL DIAGNOSIS, "the reason, after study, for admission". The principal diagnosis is used to group patients into broad categories called Major Diagnostic Categories (MDCs). The MDCs, for the 467 DRGs are arranged by organ system. For example, MDC 01 is Diseases and Disorders of the Nervous System, MDC 02 is Diseases and Disorders of the Eye. Because a physician's practice is based upon organ systems, the physicians on the National Steering Committee felt that grouping diagnoses by organ system best reflects medical practice.

Each MDC was subdivided into DRGs based on variables, such as age, sex, secondary diagnoses, procedures and discharge status, which made a significant difference in the length of stay (LOS) of patients. Length of stay is usually used as a surrogate for resource consumption.

In constructing the 467 DRGs, Yale used a nationwide sample of 1.4 million medical discharge abstract records plus 330 thousand New Jersey records which contained cost data as well as medical information. Cost data was used to confirm the relationship between length of stay and resource consumption. If resource consumption correlated with LOS for a DRG, there was no modification of the DRG. If resource consumption did not correlate, then modifications were made to the DRG.

The National Steering Committee was composed of representatives from Yale, New Jersey, HCFA, the Commission on Professional and Hospital Activities

(CPHA), Public Health Service, and Johns Hopkins University. This committee membership was half physicians. In addition, a separate review structure was set up in New Jersey composed of physicians, medical record professionals, and other individuals with DRG expertise. The New Jersey group reviewed all decisions made by the Steering Committee and made recommendations based upon their experience with DRGs. The resulting MDCs and DRGs are contained in a computer program called "GROUPER". There was a great deal of clinical input, as well as cost data correlation. Hence, the DRGs are meaningful in terms of actual clinical practice and "real life" experience.

B. Outliers

Even with a sophisticated patient classification scheme such as DRGs, there are still those patients who are truly unique and cannot be compared to other cases. Those patients, because of their condition or treatment, have atypical resource consumption, and are considered "outliers".

New Jersey uses seven outlier categories—low length of stay, high length of stay, patients admitted and discharged the same date, patients who died, patients who left against medical advice, clinical outliers and low volume outliers.

Each DRG has a range of days that a typical patient would stay. The first day of the range is the "low trim" point, the last day of the range is the "high trim" point. Patients whose LOS is shorter than the low trim point are low length of stay outliers; patients whose LOS is longer than the high trim point are high length of stay outliers. Patients who were admitted and discharged on the same date, who died or who left against medical advice are considered atypical in terms of resource consumption in an acute care inpatient hospital setting.

There are also DRGs that were considered by the physicians to contain patients with diverse medical problems, so it was not equitable nor reasonable to set an "average" rate for the patients in those DRGs. Those DRGs are called "clinical outlier DRGs". In 1982 and 1983, there are 97 clinical outlier DRGs for purposes of billing.

In addition, there are hospital specific DRGs which have such a low frequency (fewer than 6), that an average rate for those DRGs could not be determined. Patients falling into such a low-volume DRG are considered outliers.

Patients in all outlier categories are billed itemized charges instead of the DRG payment rate.

The percentages by outlier categories in New Jersey's 1.1 million 1979 abstract records, regrouped into the 467 DRGs, are as follows:

	Percent
Low LOS (including same day stays)	8.7
High LOS	9.8
Deaths	5.5
Left against medical advice	1.8
Clinical outlier groups	6.3
Total	32.1

About one-third of the inpatients in New Jersey hospitals in 1979 were atypical based upon the New Jersey outlier criteria.

C. Secondary diagnoses, procedures, DRG creep

It was found in the old DRGs, that the order of secondary diagnoses or procedures could change DRG assignment and affect hospital reimbursement.

The term "DRG Creep" was coined to describe deliberate and systematic ordering of secondary diagnoses or procedures to obtain the highest reimbursement. In some instances, rearrangement of principal diagnosis was also attempted. DRG Creep was a problem with the old 383 DRGs because the computer could use only principal diagnosis, first listed secondary diagnosis, and principal procedure (very rarely were secondary procedures used). Therefore, hospitals could order the codes for maximum reimbursement.

New Jersey instituted strict definitions. First and most important, principal diagnosis was defined as the reason, after study, that the patient was admitted. In accordance with the Uniform Hospital Discharge Data Set definitions, additional diagnoses were to be coded only if they had bearing on the treatment or length of stay. There was a four part definition of principal procedure.

The view of New Jersey was that if a hospital did indeed treat a patient for a severe secondary or perform multiple severe procedures, then the reimbursement should be reflective of this resource consumption. However, the necessity for treatment must be documented in the medical record, and those procedures performed must also be documented.

So, not only did the State of New Jersey institute strict definitions of what diagnoses and procedures could be coded for DRG assignment, it also mandated that documentation for everything be present in the medical record.

DRG Creep is not a problem with the 467 DRGs. The computer program selects the secondary diagnosis codes or procedure codes needed for DRG assignment. The ordering of the codes does not matter because GROUPER searches all codes listed in the record. This computer program is "smarter" than the old program. Significant secondary diagnoses and procedures which affect resource consumption will be taken into account when the payment rates are calculated.

DATA REQUIREMENTS

The data requirements for the DRG patient classification system are massive. The proposed Medicare Prospective Payment System (PPS) may not have the same sheer volume of data (asbstracts, bills, cost reports and Uniform Bill-Patient Summary) but the principles will still apply.

Hospitals must have computer capabilities. The 467 DRGs cannot routinely be assigned by hand. There must be the capability for all pieces of a patient's record to flow to a central point for DRG assignment. (See Attachment B). Collection of the pieces and DRG assignment must be done as rapidly and efficiently as possible. There must be the capability to verify and correct records. There must be the clincial or financial management information. Above all, the hospital and its billing and medical abstract vendors must understand how to work with the DRG system.

Hospitals are not the only agencies which need to have computer capabilities. The volume of data received necessitates computer capability at the intermediary and payer level. They must have the ability to collect, verify and correct data submissions. They must be able to check DRG assignment and dollars charged. They must have edit and submission checks to obtain accurate data on a timely basis. Data requirements and timeliness for data submission should be worked out ahead of time and then enforced.

IMPLEMENTATION

During 1978 and 1979, while in a developmental mode, New Jersey established experimental rates for approximately 20 hospitals. The rates were based upon available data sets and various methods of calculation were utilized. This experiment allowed refinement of both the data sets and the methodology as a result of the hospital's experience with the experimental rates.

Even though New Jersey had a two year simulation, implementation brought additional problems which were not fully anticipated. Examples of these problems were data management (at all levels) and concern about quality medical care.

A. Data management

The logistics of data management and reporting presented an enormous challenge. There have been refinements made each year and continued simplification. Despite these refinements, one of New Jersey's main problems remains the sheer volume of data and the errors involved in manipulation of a massive data base (1.2 million hospital inpatients per year). Data quality, timeliness of submissions, correction turn-around time, and programming have all presented problems. These problems were uncovered in 1980 when New Jersey implemented the DRG system for 26 hospitals, two intermediaries, and 380 thousand patients. It is conceivable that Medicare may experience some difficulties implementing a system for 6,000 hospitals, 100 intermediaries and 10 million patients. The disruptions and changes caused by the discovery and correction of problems were minimized in New Jersey by phasing-in the system with only 26 hospitals rather than all 100 acute care hospitals.

B. Quality of care

Since the DRG system provides incentives for hospitals to reduce LOS, there was concern expressed that quality of care would suffer (e.g. patients discharged too early). Likewise, since there is an incentive for hospitals to decrease unnecessary resource consumption, the question of decreasing quality by utilizing fewer tests or other resources was raised by some critics of the DRG system. The Professional Standard Review Organizations (PSROs) have become the focal point for addressing quality of care issues. New Jersey has found no evidence that quality of care has diminished under the DRG system.

While great care can be taken to anticipate and resolve problems prior to implementation, additional problems will be discovered when the system is actually in place and functioning. It was for this reason that New Jersey phased-in hospitals over several years. A phase-in of the system affords the opportunity to correct problems with fewer repercussions.

OTHER ISSUES

A. Education

There are several other issues that should be raised. The first is the tremendous importance of education for hospitals, physicians, patients, intermediaries, PSROs, and planning agencies. Hospitals must learn to use DRGs to manage clinically, operationally and financially in the most efficient manner. The importance and dire necessity of thorough education of a hospital's medical staff cannot be over-emphasized. Physicians must understand their role in hospital resource consumption. Patients must understand the classification and billing. Intermediaries must understand DRG assignment and claim check. PSROs must understand their role in assuring quality data and quality care under DRGs. Planning agencies must be able to use DRGs as tools to make their planning decisions.

If the entire hospital is not involved in the DRG system, then the hospital cannot effectively function under DRGs. Attachment C lists areas of management consideration for a hospital going onto DRGs.

New Jersey has had many calls from outside the State from agencies and individuals concerned about DRGs and Medicare. The level of knowledge ranged from some familiarity to total ignorance of even simple data requirements.

B. Monitoring

The second issue is the importance of monitoring quality of care. Quality of care is very difficult to measure. Can quality be measured by a criterion such as outcome—alive/dead? In New Jersey, we believe that peer review is an important component in monitoring quality of care, and the PSROs serve this function. The value of an independent organization to monitor the utilization of hospital care cannot be refuted.

C. New Technology

Third, there should be a mechanism for addressing new technology. In New Jersey, the Rate Setting Commission hears testimony from a hospital (or hospitals), the Department of Health, and the Commissioner's Physician Advisory Committee. If evidence is available that a new technological advance is worthwhile, then the hospital is awarded additional reimbursement.

The hospital can also obtain additional reimbursement for new technology through the appeals process for those approved certificate of need projects.

D. State flexibility

It is important to note that while the problems of rising hospital costs may be similar nationally, a prospective payment system may not have identical results in Idaho as in Pennsylvania. In those instances where a state can implement their own system, designed to meet the federal objective, then flexibility or waivers for state initiatives should be allowed.

SUMMARY

In conclusion, we in New Jersey have been working with DRGs since 1976. We feel very strongly that DRGs have a great benefit in terms of allowing hospitals to use available resources wisely and to help contain healthcare costs for payers and consumers.

Now that all New Jersey acute care general hospitals are finally billing by DRGs, we should be in a position to see exactly how much of an impact DRGs can have on a state's health care expenditures and clinical management.

ATTACHMENT A

[Material from report to Congress, hospital prospective payment for medicare, December 1982, Richard S. Schweiker, Secretary, Department of Health and Human Services.]

U.S. COMMUNITY HOSPITALS
1975–1980
PERCENT INCREASE
EXPENSE PER ADJUSTED ADMISSION

RANK	STATE	CUMULATIVE INCREASE	ANNUAL INCREASE	
1	ALASKA	149.67	20.08	
2	DISTRICT OF COLUMBIA	123.12	17.41	
3	NEVADA	111.88	16.20	
4	NEW MEXICO	111.71	16.18	
5	MONTANA	109.36	15.93	
6	WYOMING	108.14	15.79	
7	HAWAII	107.54	15.72	
8	UTAH	104.99	15.44	
9	KANSAS	100.13	14.88	
10	NORTH DAKOTA	97.30	14.56	
11	COLORADO	96.97	14.52	
12	SOUTH DAKOTA	96.18	14.43	
13	MAINE	96.08	14.42	
14	CALIFORNIA	95.23	14.32	
15	OKLAHOMA	94.57	14.24	
16	MISSOURI	93.22	14.08	
17	IDAHO	92.37	13.98	
18	ARKANSAS	90.78	13.79	
19	ILLINOIS	90.13	13.71	
20	IOWA	90.00	13.70	
21	WEST VIRGINIA	89.81	13.67	
22	OREGON	89.34	13.62	
23	TEXAS	88.20	13.48	
24	VIRGINIA	88.04	13.46	
25	WISCONSIN	87.93	13.45	MANDATORY*
26	ALABAMA	87.73	13.42	
27	OHIO	86.57	13.28	
28	MINNESOTA	85.14	13.11	
29	SOUTH CAROLINA	84.52	13.03	
30	PENNSYLVANIA	84.48	13.03	
31	LOUISIANA	83.95	12.96	
32	INDIANA	83.92	12.96	
33	TENNESSEE	83.80	12.95	
34	MISSISSIPPI	83.42	12.90	
35	NORTH CAROLINA	82.60	12.80	
36	KENTUCKY	82.02	12.73	
37	ARIZONA	80.69	12.56	
38	NEW HAMPSHIRE	78.69	12.31	
39	WASHINGTON	78.02	12.23	MANDATORY *
40	FLORIDA	77.98	12.22	
41	GEORGIA	77.49	12.16	
42	MICHIGAN	76.91	12.09	
43	NEBRASKA	74.47	11.77	
44	MASSACHUSETTS	72.41	11.51	MANDATORY*
45	NEW JERSEY	68.22	10.96	MANDATORY*
46	DELAWARE	67.56	10.87	
47	RHODE ISLAND	67.42	10.86	MANDATORY*
48	MARYLAND	67.23	10.83	MANDATORY*
49	CONNECTICUT	65.51	10.60	MANDATORY*
50	VERMONT	63.14	10.28	
51	NEW YORK	51.62	8.68	MANDATORY*
U.S. Average		79.60	12.42	
Mandatory		61.83	10.1	
Non-Mandatory		86.59	13.29	

*Those programs which require hospitals both to participate and comply.

TABLE 2

PROSPECTIVE PAYMENT EXPERIENCE:
ANNUAL PERCENT INCREASE IN INPATIENT HOSPITAL COSTS
DEMONSTRATION STATES VS UNITED STATES

Community Hospitals: Annual Percent Increase
Inpatient Cost Per Capita

States with Demonstrated Programs	1977	1978	1979	1980	1981
Connecticut	10.6	9.4	9.0	12.6	14.1
Maryland	11.3	11.8	15.1	14.5	16.0
Massachusetts	11.9	7.3	8.2	13.9	14.4
New Jersey	11.7	8.8	10.6	15.8	11.5
New York	11.5	7.5	10.0	11.5	15.2
Rhode Island	10.0	6.7	12.9	14.0	15.0
Washington	11.9	7.0	9.1	11.3	21.8
Wisconsin	10.2	11.5	10.8	14.7	16.9
United States	12.8	11.1	12.0	14.9	17.7

COST PER CAPITA
COMMUNITY HOSPITALS

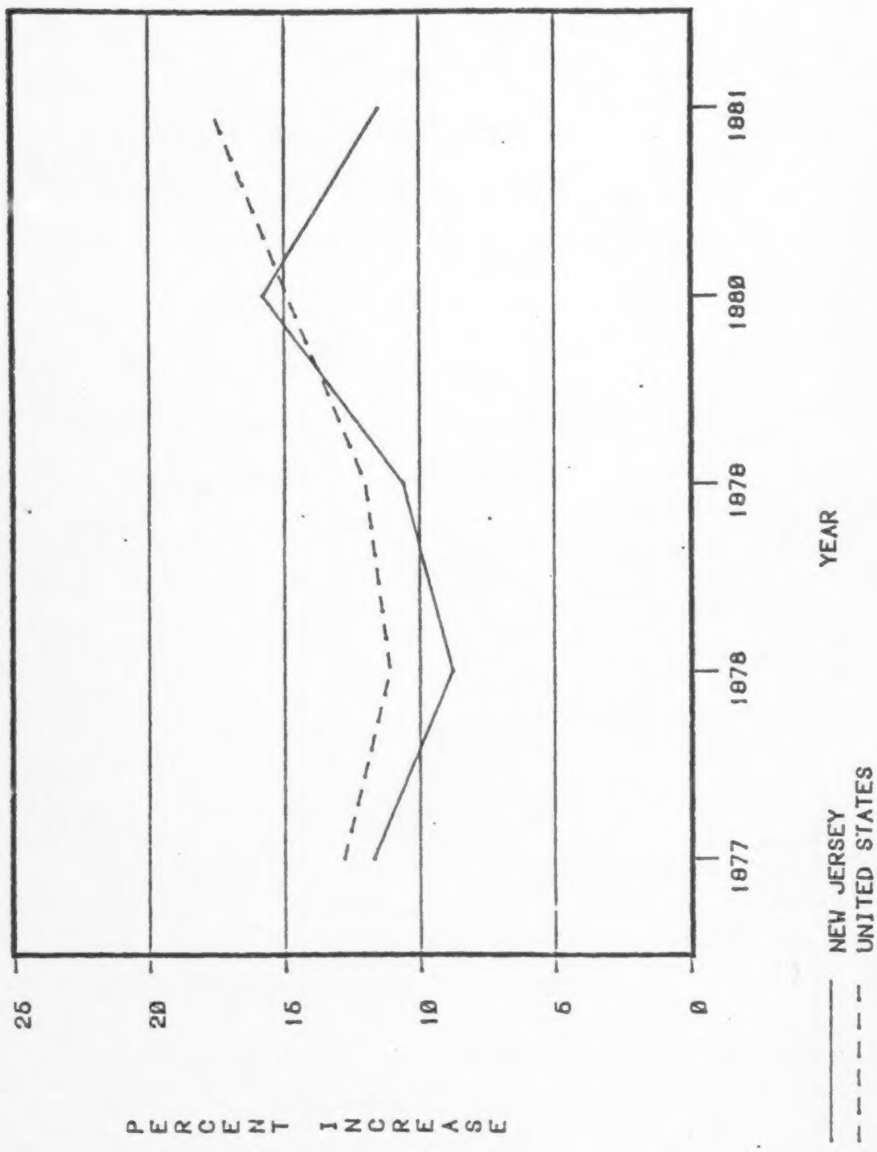
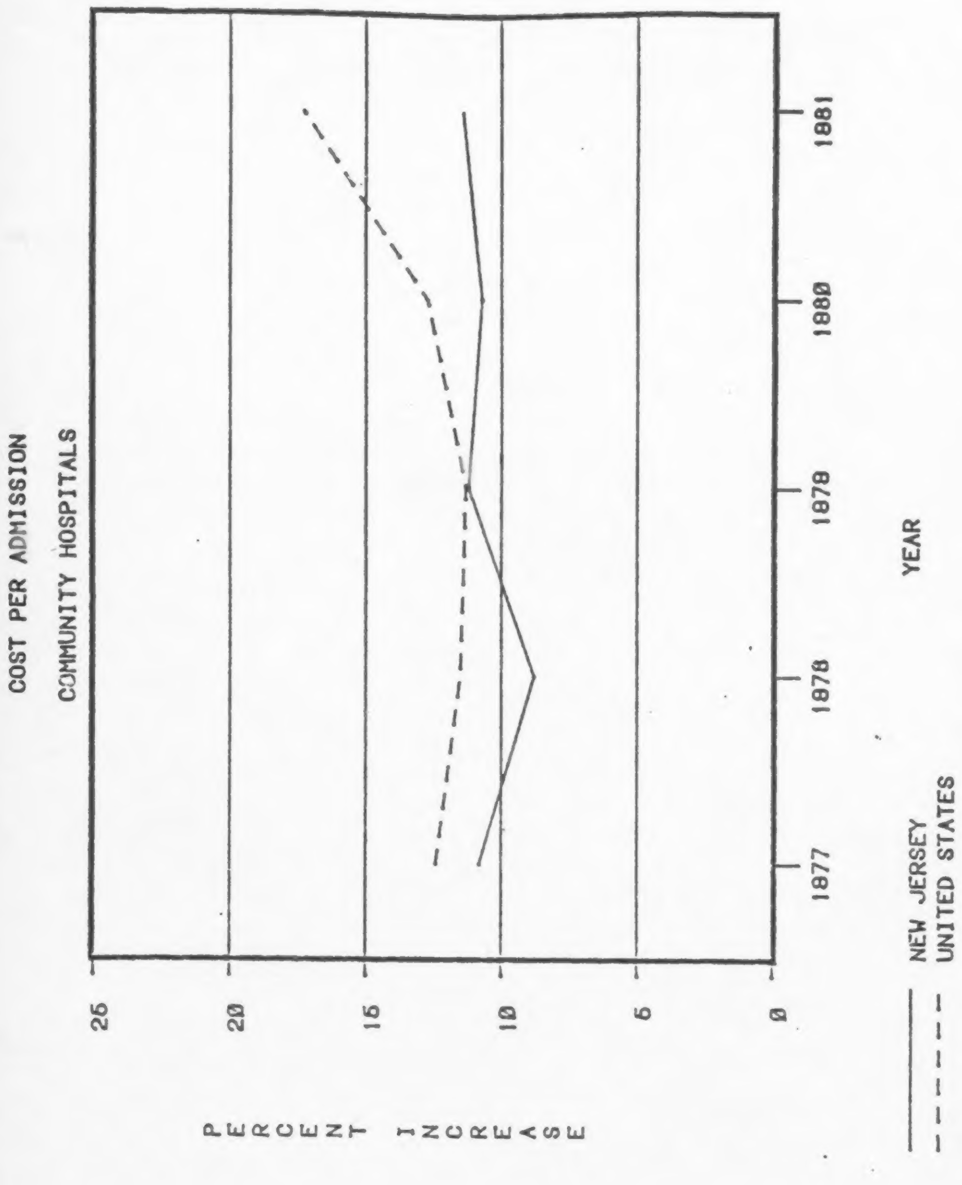


TABLE 3

PROSPECTIVE PAYMENT EXPERIENCE:
ANNUAL PERCENT INCREASE IN INPATIENT HOSPITAL COSTS
DEMONSTRATION STATES VS UNITED STATES

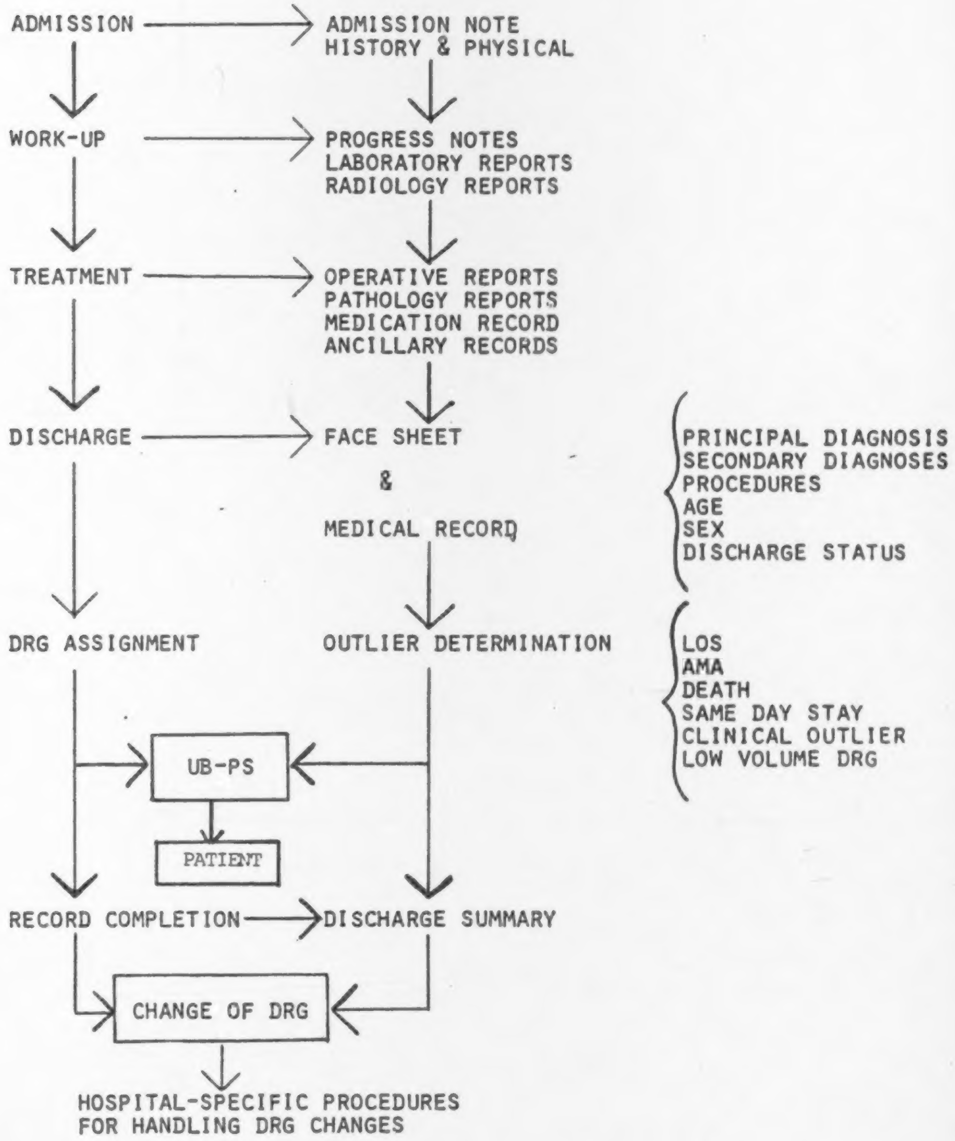
Community Hospitals: Annual Percent Increase
Cost Per Adjusted Admission

States with Demonstrated Programs	1977	1978	1979	1980	1981
Connecticut	11.1	9.5	8.1	11.4	15.9
Maryland	8.9	9.2	12.1	9.8	15.6
Massachusetts	13.8	8.1	7.6	14.1	14.1
New Jersey	10.8	8.8	11.2	10.7	11.4
New York	7.0	8.5	8.5	10.8	14.1
Rhode Island	9.5	6.1	10.9	12.4	16.3
Washington	12.9	10.5	11.2	10.9	18.9
Wisconsin	12.5	12.7	10.7	12.6	17.6
United States	12.4	11.5	11.3	12.7	17.3


COST PER ADMISSION
COMMUNITY HOSPITALS
PERCENT INCREASE
25
20
15
10
5
0
1977
1978
1979
1980
1981
YEAR
NEW JERSEY
UNITED STATES

ATTACHMENT B

INFORMATION FLOW



ATTACHMENT C

MANAGEMENT CONSIDERATIONS

1. Staffing—Personnel requirements and training.
2. Systems analysis—Review; discharge processing; chart completion; timing of DRG assignment; and computerization—vendors.
3. Interaction with other departments—Admissions; billing/finance; utilization review; DRG coordinator; administrator; medical records; nursing; and social services.
4. Physician involvement—Accuracy of information; timeliness of record completion; and education—DRGs and MDs.
5. Monitoring—internal and external—Accuracy of DRG assignment; data quality; incomplete charts; edits on UB-PS, abstracts; and outside monitoring.
6. Data analysis—Management reports—DRG; volume frequency; physician and service; outliers; cost analysis; others—LOS, variance.

Chairman **JACOBS**. Thank you.

Mr. **MOORE**. I would like to compliment the representatives from Maryland and New Jersey, in particular for the leadership they have undertaken in this field, and in particular Ms. Goldschmidt. I appreciate your comment in your testimony that there was no evidence, according to your independent monitoring, that the DRG's had any negative effect on the quality of health care.

That is something that concerns, I think, the entire public.

Thank you for coming. I appreciate your testimony.

Chairman **JACOBS**. Mr. Shannon.

Mr. **SHANNON**. No questions.

Chairman **JACOBS**. Well, I am glad you all got here. You have all made your contributions. We express our gratitude.

Next, the Group Health Association of America, Inc., represented by Candace Keller.

STATEMENT OF CANDACE KELLER, LEGISLATIVE COUNSEL FOR GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Ms. **KELLER**. I am Candace Keller, Legislative Counsel for Group Health Association of America. My association represents over 100 prepaid group practice health plans, a majority of the group and staff model health maintenance organizations [HMO's] in the Nation. Our member plans serve approximately 8 million enrollees, 80 percent of the total national HMO enrollment.

GHAA welcomes the opportunity to comment on the administration's medicare hospital prospective payment proposal. Payment for health services provided by HMO's has always been on a predetermined, prospective basis, a major contributing factor to our ability to provide high quality, cost-effective health services to our enrolled members. Both the Congress and the Department of Health and Human Services have already made a commitment to prospective reimbursement for HMO's, in particular, through enactment and progress toward implementation of a new medicare payment mechanism for HMO's contained in the Tax Equity and Fiscal Responsibility Act of 1982 [TEFRA], section 114, Public Law 97-248. We commend Secretary Schweiker and the administration for their recognition of prospectively determined payment as an important element in their strategy to contain medicare costs.

Before commenting further on the implications for HMO's of the administration's new payment system, it is important to point out that in general DRG-based and other similar hospital reimbursement systems create problems for HMO's. A fundamental incompatibility exists between internal HMO mechanisms to promote the cost effective delivery of care and an external system intended to promote cost effectiveness generally. The resulting conflict neutralizes and even reverses HMO incentives for the efficient use of health care resources.

During the development of its hospital prospective payment proposal based upon diagnosis related groups—DRG's—the Department of Health and Human Services has made serious efforts to fashion a workable provision for HMO's. While we have not seen the legislative proposal and therefore cannot comment on it, we are aware that approaches are being considered which would permit needed flexibility for HMO's, and we are grateful for the time and attention the Department has given to addressing the special characteristics of HMO's.

The clearest example of HMO difficulties with DRG-based ratesetting is found in the New Jersey all-payor system. There, HMO's and other providers must pay rates based upon DRG's reflecting average community patterns of providing health care services. Where the usual length of stay of HMO members is shorter than the community average, where the HMO performs preadmission diagnostic testing in its own out-patient facilities that would otherwise be performed in a hospital, and where HMO patterns of practice otherwise differ from those in the community, the HMO must through the DRG rate pay for services not used.

The unfortunate result is that while the new incentives may promote greater efficiency in the health care community at large, HMO disciplines are weakened. This, in turn, can lead to a gradual increase in the HMO's length of stay experience, as well as a loss in the HMO's ability to exert cost control pressures on their participating hospitals. In fact, Touche Ross & Co., auditors for the Rutgers Community Health Plan, recommended to the plan in a management letter last year:

> (Under DRGs) if pre- or post-hospitalization services are currently being provided at the health center, and it is anticipated that a patient will not fall outside the trim points, the plan may want to have such services performed in the hospital rather than the health center, thus resulting in a shifting of costs to the hospital.

While the Touche Ross recommendations might be in the HMO's best short-term economic interest, the advice would lead to a shift in services to more costly hospital facilities, clearly counter to HMO principles of operation and to the objective of containing costs in the health care system overall. Absent legislative recognition of the incompatibility of DRG's with accepted HMO practices, medicare will face the same problem as New Jersey's HMO's, because it will be required to pay for services not rendered or rendered at a higher cost in an in-patient setting.

HMO's are now reimbursed by medicare in several ways, and the impact of a DRG-based reimbursement system for hospitals depends upon the contracting method used. Those HMO's contracting on a cost-basis under section 1833 of the Social Security Act are reimbursed for part B services only, and therefore will be little affected.

Section 1876 of the Social Security Act contains a cost-based reimbursement option under which HMO's provide both part A and part B medicare services to enrolled medicare beneficiaries. The HMO can elect to be reimbursed for part A services and in turn to make payment to the hospital or can avoid processing hospital reimbursement claims by electing to have these claims paid through the medicare fiscal intermediary. All HMO's now contracting on a cost-basis under section 1876 have elected to use the fiscal intermediary. Under this option, the HMO would be unaffected by any change in hospital payment rates and the fiscal intermediary would make DRG-based payments to the hospital directly. Reimbursement to the HMO would continue for part B services on a cost-basis.

Section 1876 of the Social Security Act, now also contains the new prospective risk-based reimbursement option enacted in TEFRA. This amendment has generated a great deal of interest among HMO's, and our major concern about DRG's arises in connection with the implementation of this provision. The new payment mechanism provides for reimbursement to an HMO prospectively at 95 percent of the cost in the non-HMO sector of providing medicare part A and part B services to a population similar in composition to that expected to enroll in the HMO—95 percent of the adjusted average per capita cost or AAPCC. The HMO must provide the part A and part B services at its adjusted community rate [ACR] its usual premium adjusted for the medicare population. Any difference between the HMO's adjusted rate and the 95-percent medicare payment, the savings, must be passed on to the HMO's enrolled medicare beneficiaries in the form of increased benefits and/or reduced cost sharing.

Under this risk-based HMO reimbursement mechanism, a DRG-based hospital payment system might affect HMO's in two ways. First, any changes in medicare reimbursement for part A and part B services clearly affects the amount paid under the AAPCC formula, and therefore DRG-based hospital reimbursement would affect the level of HMO reimbursement. The current medicare discount and any other reductions in costs reflected in the DRG-based rates would be reflected in the payment to the HMO. In this regard, HMO's would fare no differently than affected hospitals.

A more serious impact could occur with respect to the savings generated to provide additional benefits to the HMO's medicare members. Once the HMO receives reimbursement at 95 percent of the AAPCC, the HMO must negotiate its own rates with hospitals. An HMO may not have the bargaining power to negotiate rates as favorable as those resulting from the medicare discount, and therefore the HMO may have to pay more for hospital services than the medicare reimbursement levels. The HMO competes on the basis of its ability to deliver quality care in a more cost-effective manner than the predominant fee-for-service sector, but the medicare discount reflects budgetary decisions to reduce payments rather than increased efficiency. While it is common for the HMO to receive shorter lengths of stay and lower admission rates than the average in the fee-for-service sector, these and other results of HMO patterns of practice are not sufficient to put the HMO on an equal footing with the medicare discount. The result would be a higher adjusted community rate and a smaller amount of savings generated to be passed on to the HMO's medicare members. If the HMO is permitted to elect to use the medicare fiscal intermediary for part A reimbursement the problem is minimized.

In summary, a DRG-based hospital reimbursement system for medicare would not have a direct impact upon HMO's with cost-based medicare contracts unless they operate their own hospitals, in which case the HMO hospitals would be reimbursed in the same manner as all other hospitals. HMO's with risk-based medicare contracts would be directly affected by the new payment system; however, the extent of the detrimental impact is unclear. Many HMO's may well hesitate to enter into risk-based medicare contracts without first being able to realistically assess the impact of DRG-based hospital reimbursement.

HMO's are also concerned about the impact of an all-payor DRG-based hospital payment system. Because of the significant percentage of hospital costs nationwide which are paid by medicare, the use of DRG-based reimbursement may encourage, if not induce, states and perhaps some individual hospitals to move to all-payor DRG-based rates.

The Department of Health and Human Services has already indicated it would look favorably upon applications for State waivers where the all-payor systems proposed are compatible with the proposed medicare reimbursement system.

DRG-based or similar per case all-payor systems present serious difficulties for HMO's. While prospective payment is basic to HMO budgeting methods and cost containment strategies, per case reimbursement based upon community norms undercuts rather than supports HMO incentives for the efficient use of health care resources.

HMO's have developed a variety of creative arrangements with hospitals which are beneficial to both hospitals and HMO's. In negotiating with hospitals, HMO's can take advantage of the volume of predictable business they can bring to the institution; prompt payment terms; reductions in bad debts resulting from comprehensiveness of coverage, that is, no payments to collect from the patient, and guarantees of eligibility; and the benefit of progressive HMO efforts to reduce stays and contain costs such as pre-admission diagnostic testing and early discharge programs.

HMO's—those that do not own their own hospitals—employ various methods to reimburse participating hospitals, depending in part on the above factors. They may pay itemized charges or discounted charges; more typically they pay a more predictable and cost-based all-inclusive per diem rate; some HMO's contract with hospitals to pay for a given number of beds, whether fully utilized or not, providing the institution with guaranteed occupancy in consideration for a preferred rate; still other HMO's reimburse hospitals on a capitation basis, providing greater predictability of costs to the HMO and revenues to the hospital.

Regardless of the specific contractual arrangements, HMO's and hospitals cooperate in efforts to share services and optimize the utilization of resources. These can include arrangements to facilitate appropriate treatment of patients who present themselves in emergency rooms; hospitals' agreements to accept the HMO's pre-admission testing, utilization review and early discharge programs; and sharing of costly diagnostic and treatment services.

In any movement toward all-payor per case reimbursement systems, consideration should be given to preserving the negotiating flexibility needed for HMO's to continue to take maximum advantage of their existing incentives to reduce hospital utilization and contain costs. It would be unwise to disadvantage the organizations which are currently achieving many of the cost containment goals which the rate setting systems are designed to promote.

In conclusion, HMO's remain a singular model of innovation and reform in an otherwise cost-reimbursement oriented health care system. We commend the administration's efforts to treat HMO's equitably under their hospital prospective payment proposal. We urge that any new incentives injected into the system at large be crafted to recognize the difference between conventional modes of health care delivery and the demonstrated effectiveness of HMO's in providing high quality care through comprehensive prepaid direct service delivery systems.

We look forward to working with the subcommittee as the administration's legislative proposal for DRG-based prospective medicare hospital reimbursement is sent to the Congress and consideration of medicare prospective payment systems continues.

Thank you.

Chairman JACOBS. Thank you, Ms. Keller.

Mr. MOORE. Mr. Chairman, let me say I appreciate the witness coming here. You have really raised a question that concerns me as well. In a broad sense we are following your pattern, the HMO prepayment idea in our prospective reimbursement initiative. We don't want to do anything that puts HMO's at a competitive disadvantage.

I don't know what we are going to do about it. Certainly I intend to take a close look at it. We don't intend to do anything to cause you difficulty.

Ms. KELLER. We look forward to working with you.

Mr. SHANNON. No questions.

Chairman JACOBS. OK.

We will stand in adjournment.

[Whereupon, at 12:20 p.m., the subcommittee was adjourned, to reconvene on Tuesday, February 15, 1983.]

MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM

TUESDAY, FEBRUARY 15, 1983

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, D.C.

The subcommittee met at 10:15 a.m., pursuant to notice, in room B-318, Rayburn House Office Building, Hon. Andy Jacobs, Jr. (chairman of the subcommittee) presiding.

Chairman Jacobs. Let the record show this is a continuation of the hearings of the Health Subcommittee of the House Ways and Means Committee on the question of the so-called prospective payments and other reforms in the medicare system.

We are pleased to welcome our colleague not only in the House, but the Ways and Means Committee, the pride of St. Louis, Richard Gephardt.

STATEMENT OF HON. RICHARD A. GEPHARDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. Gephardt. I thank the chairman for allowing me to be here and make my testimony.

I appreciate the subcommittee having these hearings on what is obviously looming as a crisis, not only today, but in our future. Medicare will go broke before the end of the decade running a deficit predicted to be over $3 billion between now and 1995.

Clearly this is a tremendous challenge to the subcommittee and to the Congress, but in my view the challenge may have some silver linings in the dark cloud that now looms over medicare.

I have become so alarmed over the amount of the deficit and the quickness with which we will run out of money in the medicare fund that I guess you could say that today I am reversing a bit. In the past when I have talked about competition and the wonders of competition and how it can provide some answers to our health care cost problems.

I haven't lessened in my feelings in that regard, but I do now feel that because of the secret of the problem that it is essential that we move on two tracks, one for greater regulation to try to deal with the cost problem in medicare and on another track to try to open up the possibility of competition, in effect to run two experiments at once because of the crisis we face to see if either one or both together cannot begin to chip away quickly at our cost problems.

The debate over remedies I think begins with the agreement that medicare is a valuable program. No one argues about its success or the need for it. But the rising cost of health care is not a medical mystery. We already know how to deliver care at a reasonable price, we don't lack ideas, we lack the political will to implement ideas that have been proven in communities throughout the United States.

The basic problem stems I think from the fact that our health care system is disconnected. The physician selects the treatment, the patient receives it, the insurer pays for it. All the successful experiments somehow connect these activities, giving the physician more financial risk. There is no other professional in the health system whose role is of such great physical importance as the role of the physician.

Congress I think must begin to tell physicians to contain the cost of care and reward them for doing that. We know of two ways to contain medicare costs.

One is before you today, prospective payment for inpatient care, and the other way is the way we started last year as we passed the so-called HMO voucher bill. It has many other names, but it was indeed a capitation payment for comprehensive plans.

My view is that increasing the use of both of those kinds of programs at the same time will give us our best chance to try to deal with the inefficiencies in our health care system. I think both strategies have to be promoted because both tell providers in advance the amount the Government is willing to pay for health care.

Let me talk for a minute about prospective pay. I think first of all that the administration's plan is a good one, but I would add two things to it.

I believe Congress first should tell both physicians and hospitals in advance how much medicare will pay by diagnosis. In the past medicare has paid for every aspirin, every blood test and every X-ray performed in the hospital.

Under prospective payment the physicians and the hospitals would share a flat fee instead. Any such change in the way medicare pays hospitals must address several key points.

First, I think physicians should be included in prospective payments. Physicians control 70 percent of health care expenditures. I think Congress must include physicians if we are to address medicare's financial problems, and I hope to be able to introduce a bill later this week that would change the administration's plan for prospective pay to the extent that the plan I will introduce would include physicians in the flat payment that would be made to the hospital.

No. 2, I think capital costs must be included. As you know, the administration's plan does not include capital costs. They simply pass them through. When we had the hearing, you were good enough to have me there, I was able to ask whether or not they would include capital costs. I think they said they thought it was too difficult and they were going to work on it and come back with something.

The bill I will introduce will include capital costs. I think it is clear that the planning process doesn't work. The sooner we make hospitals financially responsible for their decisions, the better off medicare will be. Let me cite some statistics.

There has been a surge in hospital investment in the last 2 years. Total outlays in 35 States rose to $11 billion in 1982, up from $4 billion in 1979. Every dollar spent in capital costs raises the hospital's operating cost by 30 cents. It seems to me to leave this out as we start this program will make it very difficult for the program to succeed.

It is also clear I think that hospital building is in a real surge at this point.

No. 3, I think teaching costs should be paid separately through a fund.

No. 4, beneficiaries must have catastrophic protection. Ironically, we have never met this initial but important goal of the entire program. While some of these changes are politically very difficult, the more that is covered in prospective payments, the more incentive the providers will have to deliver efficient hospital care and the more medicare can save.

The second track I think we need to follow is the capitation payment to comprehensive plans. As I said, we started this last year by the bill we passed that deals with medicare recipients being able to use HMO's. Prospective payment is very complex and intrusive from diagnostic related groupings to pre admission certification.

I think there is a much simpler mechanism that will eventually prevail in the health system and that is capitation. I think we need to promote it at the same time we are promoting prospective payment, and I hope we include physicians to make it as strong as it can be, I think at the same time and on a separate track we need to promote the capitation system.

I would call it medichoice and have it alongside the classic medicare system. It is at once more radical, more comprehensive and I think more promising. It is basically the medicare reform that Congressman Gradison and others have been promoting for over a year.

Congressman Waxman I think must be commended for his excellent leadership in this area. TEFRA contained an important step in this direction.

Rather than paying providers by diagnosis, we would allow them to make a longer commitment. They would receive a flat payment for taking full responsibility for a beneficiary over an entire year. Here the possibilities for gain or loss are greater, as would be the opportunity for greater efficiency.

Now, the challenge is to explain the new program to beneficiaries. They could receive medicare or medichoice. Within medichoice the beneficiary could choose to enroll in a health plan. This program is already underway with three or more health plans participating in Minneapolis and Detroit.

I think medichoice offers more than incentives for efficient providers. It offers advantage to the Government in that it allows us to budget. The Government would know with certainty the cost for these patients. That is a happy contrast with the current program where providers have something of a blank check until the end of the fiscal year.

More than 1,000 participants in Worcester, Mass., receive virtually total physician and hospital coverage, eyeglasses and prescriptions with a $2 copay. That coverage only costs $15 a month and is much better than medicare and even most of the medigap policies that exist.

That in short is my vision of what we should try to do. I realize that you are on a fast track and probably a lot of the things can't be included in this round if there is an attempt to attach this to the social security bill, I understand that. But I wanted to come here to give you my views, my concern over the cost of this system and the idea that I think we have to move out as hard as we can with both the regulation scheme and the deregulation scheme to see if both of them can't give us some answers.

[The prepared statement follows:]

STATEMENT OF HON. RICHARD A. GEPHARDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

I appreciate this opportunity to appear before your committee and share my views on Medicare.

This is not an especially happy time. Government spending generally is a bleak topic because of our unprecedented budget problems. The situation involving Medicare is particularly depressing. Medicare will go broke before the end of the decade, running a deficit over $300 billion between now and 1995. More depressing is the realization that saving Medicare involves either raising taxes to an intolerable level or sharply cutting benefits.

Your committee has the challenge of finding a way to hold things together and extend Medicare's life. There is also an opportunity or positive change and I commend the chairman for holding these timely hearings. I hope I'm not a pollyanna when I take that attitude, but I believe there is tremendous opportunity to find the silver lining in the dark cloud looming over Medicare.

The debate over remedies begins with agreement that Medicare is a valuable program. No one argues about its success and the continued need to provide the elderly access to quality health care.

But, the rising cost of health care isn't a medical mystery. We already know how to deliver quality care at a reasonable price. We don't lack ideas. We lack the political *will* to implement ideas that have been proven in communities throughout America.

Our health system is fairly disconnected. The physician selects the treatment. The patient receives it. The insurer pays. All the successful experiments connect these activities giving the physican more financial risk.

There is no other professional in the health system whose role is of such great fiscal importance. Congress must tell physicians to contain the cost of care and reward them for doing so.

We know of two ways to contain Medicare costs: prospective payment for inpatient care and capitation payment to comprehensive plans. These two strategies should both be promoted. Both tell providers in advance the amount the government is willing to pay.

PROSPECTIVE PAYMENT FOR INPATIENT CARE

Despite acknowledged pitfalls, I believe that Congress should tell physicians and hospitals in advance how much Medicare will pay by diagnosis. In the past Medicare has paid for every aspirin, very blood test, and every X-ray performed in the hospital. Under prospective payment, the physicians and the hospitals would share a flat fee instead.

Any such change in the way Medicare pays hospitals must address several key points.

1. Physicians must be included. Physicians control 70 percent of health exenditures. Congress must include physicians if we are to address Medicare's financial problems.

2. Capital costs must be included. It is clear that the planning process does not work. The sooner we make hospitals financially responsible for their decisions, the better off Medicare will be.

3. Teaching costs should be paid separately through a fund.

4. Beneficiaries must have catastrophic protection. Ironically, we have never met this initial, but important goal of the program.

While some of these changes are politically difficult, the more that is covered in prospective payment, the more incentives the providers will have to deliver efficient hospital care and the more Medicare will save.

CAPITATION PAYMENT TO COMPREHENSIVE PLANS

Prospective payment is very complex and intrusive from diagnostic related groupings to preadmission certification.

There is a much simpler mechanism that will eventually prevail in the health system-capitation. We need to promote what I call Medichoice. It is at once more radical, more comprehensive and more promising. It is basically the Medicare reform that Congressman Gradison and I and others have been promoting for over a year.

Congressman Waxman must also be commended for his excellent leadership in this area. TEFRA contained a step in this direction.

Rather than paying providers by diagnosis, we would allow them to make a longer commitment. They would receive a flat payment for taking full responsibility for a beneficiary over the year. Here the possibilities for gain or loss would be much greater, as would the opportunity for greater efficiency.

Now the challenge is to explain the new program to beneficiaries. They could receive Medicare or Medichoice. Within Medichoice the beneficiary could choose to enroll in a health plan. This program is already underway with three or more health plans participating in Minneapolis and Detroit.

But Medichoice offers more than incentives for efficient providers. It offers advantages to the government in that it allows us to budget. The government would know with certainty the costs for Medichoice participants. That's a happy contrast with the current program where providers have something of a blank check until the end of the fiscal year.

Less obvious, but equally important, are the advantages to the beneficiary. They could enroll in a health plan that would emphasize keeping people well so as to minimize their demand for medical care. The result can be impressive.

More than 7000 Medichoice participants in Worcester, Massachusetts receive virtually total physician and hospital coverage, eyeglasses and prescriptions with a $2 copay. That coverage only costs $15 a month and is much better than Medicare and even most of the medigap policies.

Chairman **JACOBS**. Thank you.

Mr. Moore.

Mr. **MOORE**. Mr. Chairman, I want to compliment the gentleman from Missouri. He has been very long and diligently interested in the high cost of medical care. He has been the leading authority now for three Congresses in the pro-competition model of health care delivery and I have been privileged to be with him in his legislative efforts.

I think the prospective form of reimbursement is an integral part of that pro competition model, H.R. 850. We hope to get that part moving now, but more will need to be done.

I think the gentleman's testimony points that out for us. We thank him for his continuing interest in the testimony he brings us today. I don't disagree with the gentleman's comments.

Mr. **GEPHARDT**. Thank you.

Chairman **JACOBS**. Mr. Shannon.

Mr. **SHANNON**. Mr. Gephardt, I want to thank you for your testimony, too. You seem to be urging things which go a little bit beyond, quite a bit beyond perhaps what the administration is talking about at this time and what we are considering. I would like to ask you about this whole fast track idea.

Is it your feeling that we should fast track this proposal or should we hold back perhaps a little bit and take a closer look at it to see if we can expand on the scope of it beyond what we would likely do in the next few weeks.

Mr. GEPHARDT. I guess if I had to choose, I would say if we can do it now, we ought to do it even if it is not the perfect product and has not been completely thought through, if you will.

My ideas go beyond that. I would be putting physicians in and paying the hospital for the physician and the hospital. That is a radical departure from what the administration is saying.

I don't think you can do that on this fast track obviously. Let me tell you why I think it is important to move ahead.

The information I have says that by 1987 medicare is going to be out of money even if we pass the social security bill we are talking about passing, which is going to be difficult to pass in and of itself. I think that is a crisis.

I don't know how you define a crisis, but that to me is a crisis. It means by 1987 we either have to find between now and then some very real cost savings in medicare, knocking out inefficiencies that exist, or we have to raise the tax tremendously.

I am told we would have to raise the tax to cover the deficit from 1.3 percent to 2.5 percent. You know the tax increases that are in the social security bill for the pension program. I just don't see our ability to pass such tax increases.

So, we have a crisis and the sooner we get on to solutions, the better off we are going to be. If we wait to pass the bill until the middle or the end of the year, which is probably what it will take if we miss this opportunity. It would take that much longer for HHS to make prospective pay work and it will be a horribly complicated scheme of regulation. You are going to have 400 different categories of payment for 400 different kinds of ailments.

Mr. SHANNON. Are you suggesting this be done as part of social security legislation or fast track apart from social security?

Mr. GEPHARDT. Either one, whatever the subcommittee deems to be the best way. I think to wait 6 months would be 6 months lost in what now is a time bomb that is ticking.

Mr. SHANNON. We had testimony that unless we broaden the scope of this thing, we might see a lot of cost shifting to other areas of medical reimbursement. I am just wondering whether or not we might take that into consideration and perhaps consider broadening the proposal a little bit. That might take a little more time than what we are considering here.

I would agree with you that this is an issue that has to be brought to a head pretty quickly and I look forward to working with you to do that.

Mr. GEPHARDT. I am worried, too, about cost shifting. I am beginning to wonder how much cost shifting there is going to be because what I sense is a revolt, not only in the medicare system to the cost, but a revolt in the private system.

In my area, and I am sure it is typical of every area, I have union organizations and business organizations now forming to try to do something about the rising cost of health care.

Both employees and employers simply cannot pay premiums that they are being asked to pay. So, I am not sure how much cost shifting they are going to put up with.

Mr. SHANNON. Thank you very much for your testimony.

Chairman Jacobs. Dick, I believe in the so called social security package there is a proposal for continuing borrowing by the Old Age and Survivors Trust Fund from the Medicare Trust Fund.

Is that wise to allow that under the circumstances?

Mr. Gephardt. I don't think it is because it is obvious that medicare is going broke.

If my information is correct, we borrowed, say, $15 billion, in that neighborhood, so far, probably won't borrow much more, but it is likely that HI would have to borrow $300 billion from the pension fund in 1995.

Obviously that money is not there. I think rather than leaving that in place or perhaps in addition to leaving that in place, we have to find other preferred ways of taking care of our cash flow problems in the pension fund in the mid eighties. I don't know what they are. Maybe borrowing from general revenue would be better because it is silly to borrow from HI.

Chairman Jacobs. On the subject of catastrophic coverage which you mentioned rather quickly, could you slow the tape a little and tell me what scheme you have in mind for catastrophic coverage?

The administration is suggesting a sacrifice on the part of patients, really most patients that have the relatively shorter stays in hospitals. They would pay more and in return for that they would receive catastrophic coverage if they were there for 30 years or something.

Do you have an opinion on that?

Mr. Gephardt. In my bill we will not call for that kind of trade. We will simply put in place a catastrophic program. It is my feeling that we can get as much efficiency as we are going to get out of the health care system if we proceed on the two tracks I mentioned.

I don't think you will get a good deal out of copay that the administration thinks they are. I think you are going to get greatest savings through a good hard prospective payment plan and medichoice alongside of it.

Obviously both will have some copay involved, but I don't think you will get a great deal more efficiency out of the system by increasing the copay a great deal.

Chairman Jacobs. Thank you very much. As usual, your testimony is concise and your proposal is well thought out.

I note we have had several Members of Congress testifying before the committee. If you will look, you will find we don't say that every time.

Mr. Gephardt. Thank you very much.

Chairman Jacobs. Our next witness is Dr. Carolyne K. Davis, representing Health Care Financing Association, Department of Health and Human Services.

STATEMENT OF CAROLYNE K. DAVIS, PH. D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY PATRICE HIRSCH FEINSTEIN, ASSOCIATE ADMINISTRATOR FOR POLICY

Dr. Davis. Good morning, Mr. Chairman.

Chairman JACOBS. Dr. Davis, you are welcome and admired and not envied.

Dr. DAVIS. It is a great challenge. I appreciate the opportunity to be here. Frequently when we appear in front of you as administration witnesses you offer a dollar to the individual who can be the most brief in terms of his opening statement.

I would like to say that the majority of times I can't compete for that dollar because of the extensive nature of our comments. I would, however, like to say in demonstrating fiscal prudence today, that we believe Secretary Schweiker's statement made previously should stand for the record and we are here to answer any questions that you would care to ask.

Chairman JACOBS. I am not sure what the Constitution provides for payments between the coordinate branches of the Government.

Dr. DAVIS. I would like to donate it to the Federal deficit.

Chairman JACOBS. There are certain problems about the separation of powers, but if you win——

Mr. MOORE. She did.

Chairman JACOBS. I understand that. You took 45 seconds. If you win, your prize money will be directed to the U.S. Treasury for application to the dollar debt.

Dr. DAVIS. Thank you, Mr. Chairman.

Chairman JACOBS. Dr. Davis, we thank you for being here. I have a concern about cost shifting under the proposal sent to us by the administration. There have been various remedies offered. Cost shifting has been going on, I think it is going to continue unless something is done. One suggestion was obviously to expand this idea of the DRG to all payers.

What is the position of the administration on that proposition?

Dr. DAVIS. Our position is that we believe that we demonstrated our ability to develop a new prospective system that we are confident will work for medicare.

If other providers want to utilize that, we think it should be their own decision to use it and we should not mandate it upon them. However, I would like to point out I think there are enough other remedies in the system that it is unlikely that a great deal of cost shifting could take place.

For example, we already have limits on the skilled nursing facility part of a hospital so that the hospital could not shift its overhead cost to that.

In terms of the outpatient components, there is only about $2 billion there. That is still cost based and will continue to be until we have a better method by which we can integrate it into our system. We will continue with audits on that part.

I think our pass through components—capital and the medical education—will clearly still be auditable.

To make certain there will not be any shifting from a part A service to a part B service, we are introducing a legislative proposal that will prohibit the billing of a hospital inpatient service under part B.

Mr. MOORE. I appreciate those comments. I am thinking more of the shifting from medicare to charge payers. That is a place where cost shifting could occur.

Another point raised by Mr. Gephardt in his testimony a few minutes ago, and it has been raised by other people as well as by the Secretary before the full committee. is why we are allowing capital costs to be passed through and why it is not part of the DRG.

I believe the Secretary said he hoped to address that at some point in the future. How far in the future?

Dr. DAVIS. I would say it will probably be a year or two, Mr. Moore, because we have recently given some research grants to look at this whole area. Frankly, we felt that we do not have the methodology and data base on which to develop that.

Although it is our intent to integrate it within the system in some feasible way, the problem at the moment is that we need better data on which to make our own judgments. I think it will take us 1 to 2 years before we will have that data.

Mr. MOORE. So you are telling me it is not a matter of being able to construct the language legislatively; it is a problem of the economic basis on which to construct the language.

Dr. DAVIS. Yes.

Mr. MOORE. Another question that has come up, in our efforts to mark up this legislation quickly and we hope that to be the case, is the concern that several of us have regarding the treatment of HMO's under the proposal.

Is the administration flexible in terms of supporting reasonable changes, consistent with the basic same framework of the proposal and cost to the Government?

Dr. DAVIS. We constructed what we felt was our very best proposal. Obviously, we are interested in working with Congress. We believe that prospective payment is something that should be implemented and we stand ready to work with you to make comments on your own suggestions for changes.

In terms of HMO's, we will have language that will mean that HMO's can be taken care of within the system.

Mr. MOORE. In the existing language you are giving us?

Dr. DAVIS. Yes, I think it would be in there.

Mr. MOORE. We will look at that. We don't want to do anything to discourage the HMO.

Dr. DAVIS. We have had meetings with them to make certain it will not.

Mr. MOORE. The last question I have gets back to the cost-shifting proposition.

Since you oppose coverage of all payers, it would appear to me to be an improvement over the system you are proposing if the DRG system could be made more competitive in order to discourage cost shifting.

I asked several witnesses yesterday in the hearing about creating a system wherein in a community where you had more than one hospital, of allowing a hospital that wished to charge more than the DRG rate, up to some specified limit, to do so if there is another hospital in the same community that would provide the service for the DRG rate, or less. In order to provide patients with incentive to use the lower cost hospital, their medicare deductible could be reduced.

The cost to the program could be the same, perhaps a little bit less while the cost to the patient could be a little bit less. It would cause hospitals to begin to compete since those that wished to charge more would be in danger of losing patients to hospitals charging less. It seems to me that would inhance competition which is what we are trying to encourage.

What would be your comments on something like that?

Dr. Davis. I believe we would be against that proposal because, as I understand it, you are suggesting that the hospital would either be on assignment or nonassignment. Our stand is that the hospitals should be as they now are, required to take assignment.

Mr. Moore. I understand what the position is now. I am asking you to think and give me an interchange on new ideas. I know what your proposition is now. I think we will see that the hospitals having a choice between assignment and nonassignment will take assignment and do the cost shift as they are doing now. Your system will offer no change in that except a savings to the medicare and medicaid programs. It will have no real impact on overall spiraling costs.

My concern is the greater cost of health care and not just medicare.

Dr. Davis. We believe the prospective payment system will bring about changes in behavior. Our assumption is that if you were to allow hospitals to charge more than the DRG rate for a particular beneficiary, they would not have the incentive to change their behavior pattern.

I think that would defeat what we are trying to accomplish, sir.

Mr. Moore. Under the system of competition if there was a hospital down the street that was charging less, wouldn't it have an effect on the higher cost hospitals?

Dr. Davis. I thought I heard you say that the hospital would be free to charge the beneficiary more than the DRG rate?

Mr. Moore. Only if there was another hospital that would be charging the DRG, or less. Say we put a 10-percent cap above the DRG as being the maximum amount the hospital could charge the patient. Some hospitals are inefficient in heart transplants, others are efficient. To have both of them charge the same thing would be begging for a cost shift to other payers.

If the patient desires to go to the inefficient hospital and he has the money to pay the 10 percent above the DRG, let the patient pay for that choice.

If there is another hospital in the community that would charge the DRG, or less, it seems to me that we would have built an incentive in the system for the patient to go to that hospital since the patient's deductible would be reduced.

Dr. Davis. I would be skeptical of that because my concern again is that we think the prospective payment system is a device that will give the management tool to institutions to significantly change their behavior practice.

To the degree that one allows for charges over and above that, then I am concerned that we would not see the change in the behavior that we would hope to have.

Mr. Moore. I appreciate your comments, Dr. Davis, but I think your theory on that point has not worked. TEFRA and all the squeezing we have tried to do has not stopped cost shifting and will not stop it.

I think you will find high cost hospitals that are forced to take the DRG rate, will shift their excess costs to private payers.

There is a considerable body of thought that prospective payment, which I support, will not stop cost shifting. I tend to agree with you that simply forcing all payers in the country to accept a certain rate goes a little bit too far in the regulatory scheme of things to suit me.

That is why I am trying to look for another way within the competitive scheme of things to find a way to stop cost shifting. I appreciate your comments.

Chairman JACOBS. Mr. Shannon.

Mr. SHANNON. Thank you very much, Mr. Chairman.

Dr. Davis, I thank you for being here. Mr. Jacobs is a man of his word. If he owes you a buck, I will give it to you.

Dr. DAVIS. Not to me, it will be to the Treasury.

Chairman JACOBS. It will be a pass through.

Mr. SHANNON. Before you get up your hopes, I should warn you he keeps the clock, too.

Dr. DAVIS. I am confident of his integrity, however.

Mr. SHANNON. I have a parochial concern because Massachusetts is one of the States with a waiver and I was wondering how you intend to treat those States that do have waivers?

Dr. DAVIS. Most of the States that have waivers have a time limited waiver of 3 or 4 years. At the end of that time interval we assume if they are interested in filing for another demonstration, they would engage in conversations with us and would file another proposal which we would evaluate at that time.

Massachusetts has what we call an 1115 or research and demonstration waiver so that it needs to meet the criteria that any demonstration would need and it would have to be reviewed when its time limitation is up in terms of a request for further continuation.

Mr. SHANNON. You now have permanent waiver authority. Would you repeal that authority or what would you do with that?

Dr. DAVIS. Right now under TEFRA we do have a statutory authority that allows for State rate setting, provided it meets several mandatory requirements.

Mr. SHANNON. Under the proposal we are considering now, what would you intend to do with that?

Dr. DAVIS. We would propose to continue with that particular part.

Mr. SHANNON. The permanent waiver authority?

Dr. DAVIS. Yes.

Mr. SHANNON. And not repeal it?

Dr. DAVIS. No.

Mr. SHANNON. So, the States who are operating under waivers now, like Massachusetts, would have nothing to worry about until such time as that waiver time was ended, 3 years in Massachusetts' case?

Dr. DAVIS. Provided they stay within the agreements that they are under now in terms of the demonstration authority, they would have nothing to worry about.

Mr. SHANNON. Mr. Gephardt raised some questions in his testimony that I would like you to comment on.

He argued that physicians should be included in the prospective payment arrangement and that capital costs must be included. What do you think about that?

Dr. **Davis**. Let me address each one separately. Let me briefly comment on the capital costs since I have already commented once on that.

Again I believe that capital costs is an issue that we were concerned with. We felt we needed to do more research and get the data base on which to make a better judgment. To simply include capital at this point in time, we would be unduly rewarding some facilities and penalizing others until we had a better data base on which to make our judgments.

Let me move to the including of the physicians in the rate. Physicians' charges are separate from the hospital data. The hospital data is cost data. The development of the DRG resulted from using cost data and what we call an ICD 9 data base. The physicians' data that we have is not nearly as well shaped.

It uses a different coding mechanism, a CPT 4 mechanism, and it is charge based. I think we would have some difficulty putting together charge based and cost-based data and calling it a good data base at this point in time.

Mr. **Shannon**. I don't understand why.

Dr. **Davis**. One is based on charges and the other one is based on costs. The costs have been audited. The charge-based data that we have is not as good, because it does not have the same kind of background in terms of its development. I think it would be a soft basis on which to create our methodology.

Ms. **Feinstein**. I was going to add that the physicians' data is not keyed to a specific admission and a certain course of treatment. So, presumably if you were to merge those two data sources, you would be wanting to pay the hospital all of the costs of the physician and hospital for treating the patient needing a gall bladder operation.

Our physician data does not contain the course of treatment, such as a gall bladder problem. Merging those and coming out with a fair rate would be difficult to do at this time.

Mr. **Shannon**. It is undoable or is it not just able to be done at this time?

Ms. **Feinstein**. I think it is just not able to be done at this time.

Mr. **Shannon**. What is required for you to gather the kind of data that would enable you to do it?

Dr. **Davis**. It would probably take us a couple of years in order to create the data base to be able to integrate them. We would have to go back to our carriers and ask them to begin collecting that information from physicians and modifying our forms.

Mr. **Shannon**. They are not collecting the information now?

Dr. **Davis**. They are not collecting the name of the hospital in which the physician performed the service by matching the type of service which he performed with the DRG.

Mr. **Shannon**. I guess when CBO testified they raised a concern about the limited experience with DRG's. They testified that DRG the administration proposes to use is new and has not been employed to determine reimbursement rates. Studies of the system are underway, but conclusive results will not be available for some time.

How much confidence do you have in this?

Dr. Davis. A great deal of confidence. The DRG system has been under development for the last 10 years. The number of various uses that we have looked at have included the New Jersey experience with its 3 years of experience in an all payor DRG system, and the DRG as an index used by Georgia for its medicaid program and in a case-mix adjustment system for New York State.

So we have taken advantage of a number of years of study and work on this. Initially, the first generation of DRG's, the 363 DRG's, was developed for other than reimbursement methodologies. The second generation of the DRG's was developed specifically for reimbursement.

Mr. Shannon. Are there other studies of DRG underway now within TEFRA or elsewhere that you know of? CBO refers to studies underway and they will not be completed. When will that data be available?

Ms. Feinstein. I think that the Health Care Financing Review Journal of December 1982 had a number of articles researched by outside people on the effect of prospective payment on a whole variety of indices. We will continue our work in evaluating New Jersey on an ongoing basis, although that system is somewhat different from ours.

We do have some results from New Jersey already. I would characterize it as an ongoing activity.

Mr. Shannon. Thank you very much.

Chairman Jacobs. Mr. Duncan.

Mr. Duncan. Thank you, Mr. Chairman.

In furtherance of the question Mr. Shannon raised about the State waivers, we heard yesterday from a number of witnesses in support of State waivers.

Do I understand you to say if the State doesn't currently have a State waiver, that they might demonstrate that they can equal or do better than the medicare savings that you would approve or would give consideration to such waivers?

Dr. Davis. Yes. We have two authorities, Mr. Duncan, under which we could do that.

One is what we refer to as our research and demonstration waiver authority which I referred to as the 1115 waiver area.

We have in the last 4 or 5 months given two waivers in this area. One was to the State of New York and the other was to the State of Massachusetts. They were to demonstrate specific methodology for payments.

Mr. Duncan. Those States are high rate States? Aren't their costs rather high? For example, New York?

Dr. Davis. In each case they have rates that are higher than the United States, but New York State has been under a rate system for its private pay patients and its medicaid program.

Then we have a second statutory authority that was developed under TEFRA. This was section 101C which clearly speaks to the fact that if a State can guarantee that 75 percent of all of the payors are involved, can demonstrate savings over the 3-year period of time, and can meet other criteria that the Secretary deems essential, then that waiver would be approvable, too.

We are in the final process of developing those regulations.

Mr. **Duncan**. Under current law, reimbursement limits are established based on peer groupings of hospitals by bed size and location, so-called 223 limits.

Has any consideration been given to phasing in the DRG rates by applying them to hospitals by bed size and location?

It would appear that this addresses many of the equities, the fairness issue, being raised about the DRG system which in sudden change lumps all hospitals together for establishment of the DRG rates.

Dr. **Davis**. We looked at a number of activities and felt that the phasein that we were offering in our proposal—namely to phase in over the individual hospital's cost reporting year—should be enough because they already were included last year under TEFRA.

I think the most significant change was probably made when Congress enacted TEFRA. We believe that this was probably the most dramatic change and that having made that change, institutions won't find it too difficult to move from TEFRA to prospective payment.

Mr. **Duncan**. Thank you, Mr. Chairman.

Thank you, Dr. Davis.

Chairman **Jacobs**. Doctor, what is wrong with States' rights? Why not write something into this piece of legislation guaranteeing the right of the State authorities to take precedence over this act if they do better?

Dr. **Davis**. Our concern is if we ended up with 50 different State programs, it would take additional resources to be familiar with all of those programs and to do successful auditing to demonstrate our responsibility for the oversight of the medicare program.

Obviously Congress—when it initially developed the medicare program—felt it was important to have one program nationwide. I think our concern would be relative to trying to work with the total numbers that there might be out there.

Chairman **Jacobs**. But if we are stepping out in an uncharted mine field, wouldn't 50 heads be better than 1?

Dr. **Davis**. We have every confidence that the DRG system that we are putting forward is a good system. We think it should work.

Chairman **Jacobs**. You have to remember they had every confidence in the Bay of Pigs. Some say if the New York Times had gone ahead and printed what it knew, the best writers would have gotten smarter yet. I just mention that.

The only other two questions I have are first what about the question of further borrowing from the medicare trust fund? Have you an opinion you would care to express about that?

Dr. **Davis**. Last week we submitted a piece of paper that indicated very clearly the position of the trust fund relative to a request that Chairman Rostenkowski made to the Social Security Commissioner.

It does clearly show that if one implements the prospective payment system and the recommendations in the National Commission study, that we would be able to stay afloat until the end of this decade. But clearly I think we are all recognizing the fact that we do need to develop some longer range strategies for containing the cost of our program.

That is why we are putting forward our legislative proposal this year for the medicare reform areas. I don't have any other opinions on interfund borrowing. I think we all need to be aware of the fact that we need to work continuously to contain costs so that we can protect the integrity of the medicare trust fund.

Chairman JACOBS. On the subject of submitting a piece of paper, when do we get the bill?

Dr. DAVIS. It is in clearance now at the Executive OMB. I would hope it would be here any day now.

Chairman JACOBS. It is not just around the corner.

We thank you very much for your testimony. I regard your testimony as a challenge to the witnesses who succeed you.

For the people standing in the back of the room, you will notice there are some empty chairs up here at the committee table. I am sure without objection they can be used by anybody who cares to use them. Depending the passage of the equal rights amendment, I would say that would mean ladies first and then anybody else who would care to come up.

Now the Chair reminds the witnesses that we are under the 5-minute rule. The bell will ring exactly at 5 minutes. One would hope that the gavel will not have to fall at that point. The reward will still be there. Don't give up. There is a second prize. For whoever comes in second there is a half dollar. Somebody might even beat the 45 second mark.

In any case, the first panel is Blue Cross & Blue Shield Association and National Association of Health Underwriters with their representatives who can proceed in their own order as long as they don't take more than 5 minutes.

STATEMENT OF BERNARD R. TRESNOWSKI, PRESIDENT, BLUE CROSS & BLUE SHIELD ASSOCIATION

Mr. TRESNOWSKI. I am Bernard R. Tresnowski, president of the Blue Cross & Blue Shield Association.

I will summarize my statement and I would appreciate it if the committee would include our full statement in the record.

Chairman JACOBS. All such statements will be included.

Mr. TRESNOWSKI. We appreciate this opportunity to present our views on the administration's proposed changes in the medicare payment system. We share your concern about rising health care costs and the prospect that unless action is taken, the medicare program will face severe financial problems.

We agree that redesign of the medicare payment system is warranted if it can improve incentives for cost containment. However, all of us concerned with medicare's long-term integrity should avoid exaggerated expectations about the amount of program savings which can be achieved through improvement in payment methods.

Savings from payment reform alone will not assure solvency. However, with respect to payment, our objective is broadly the same as yours, to have payment systems that build in incentives for efficient delivery of quality health care. Per case prospective payment may be one way to achieve that objective, although it is not the only possible approach.

Unfortunately no one has found the perfect system which builds all the appropriate incentives while avoiding those which are inappropriate. We urge the Congress, in embracing a new payment scheme for medicare, to allow for the continuing development of other innovative payment schemes by retaining the present waiver authority.

Overall the Secretary of Health and Human Services' report on prospective payment is a constructive beginning toward restructuring the medicare payment program. Given the tight deadline, the report is more an outline than a definitive blueprint for reform.

Before such a major change is made in the program, much more study and information is needed on several important issues, including:

What will be the impact of the proposed changes on various types of hospitals?

What will be the longer term impact on beneficiary access to hospital service. That is, will the proposed system inevitably evolve into an indemnity program?

Since any system can be manipulated, where is the proposed system vulnerable and if the incentives can't be improved, what countermeasures are needed?

Finally, what key technical points need to be spelled out in a legislative proposal now so that we can better assess the impact of and plan the implementation of a new program.

In summary, it is our opinion that it will take time to evaluate this proposal adequately and to determine whether it is on balance better than the present system. Perhaps the diagnostic related group approach will stand the test of the evaluation. Perhaps it will not.

In any case, we do not believe that the Congress should rush to enact an incompletely evaluated proposal. We do not believe an October 1983 implementation date is realistic.

For these reasons we recommend the medicare payment changes adopted last year should be continued for the time being.

In our testimony we do two things. We outline what we believe are the critical objectives for medicare payment system and second, we discuss some of the major strength and weaknesses of the administration's proposal.

In commenting on the administration's proposal, we indicate that the proposed system has a number of promising features. We note some concern about the impact on hospitals of a national DRG price. There will inevitably be some winners and some losers.

We also note the importance of holding to the rule that hospitals cannot charge beneficiaries for any out of pocket amounts for covered services other than deductible and coinsurance amounts. We do point to the difficulty of staying with that results from the arbitrariness of the application of the national average.

We talk about increases in payments by manipulating caseload. We express concern about unbundling.

We express our concern about the capital passthrough, especially when the administration has dropped support for health planning.

We note a series of administrative and technical considerations which we think are important that this committee pay attention to.

In summary we believe the administration has taken a constructive step toward development of incentives for cost effective management of health care resources.

Adoption of this proposed system would be premature. We believe the Congress should not rush to approve the administration's proposal without a thorough evaluation and that implementation would be precipitous.

We appreciate the opportunity to present these views.

[The prepared statement follows:]

STATEMENT OF BERNARD R. TRESNOWSKI, PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman and Members of the Committee, I am Bernard R. Tresnowski, President of the Blue Cross and Blue Shield Association. The Association is the national coordinating agency for the 102 Blue Cross and Blue Shield Plans in this country. The Plans serve about half of the U.S. population. We provide privately underwritten coverage to about 85 million Americans and serve about another 17 million as fiscal agents or intermediaries for the Medicare, Medicaid and CHAMPUS programs.

We appreciate this opportunity to present our views on the Administration's proposed changes in the Medicare payment system. We share your concern about rising health care costs and the prospect that, unless action is taken, the Medicare program will face severe financial problems. This program is now an integral part of our social system and is vital to the elderly. Unfortunately, demographic projections and revenue forecasts clearly indicate a severe imbalance between Medicare's existing commitments and its capacity to finance them.

This imbalance can be improved in several ways: by raising taxes; by reducing eligibility; by reducing benefits; and by containing costs for covered services.

None of these approaches is easy, and in all probability, none is adequate alone. Action may be needed in each area to equalize Medicare revenues and spending.

Certainly, redesign of Medicare's payment system is warranted if it can improve the incentives for cost containment. Medicare's original payment method was process rather than outcome oriented and, overall, did not provide adequate incentives for hospitals to contain costs. The changes made under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) introduced some incentives to hold costs below target limits but more can be done to promote efficient management of health care resources.

Nevertheless, all of us concerned with Medicare's long-term integrity should avoid exaggerated expectations about the amount of program savings which can be achieved through improvement in payment methods. Savings from payment reform alone will not assure solvency. And, if payment "reforms" are to be the only focus of efforts to balance the trust fund, the long term integrity of the program and the protection of beneficiaries could be severely undermined. I will have more to say about the potential effect on beneficiary protection later in my testimony.

With respect to payment, our objective is broadly the same as yours: to have payment systems that build in incentives for the efficient delivery of quality health care. Per case prospective payment may be one way to achieving that objective although it is not the only possible approach. Unfortunately, no one has found the perfect system which builds in all the appropriate incentives while avoiding those which are inappropriate. Accordingly, we would urge the Congress, in embracing a new payment scheme for Medicare, to allow for the continued development of other innovative payment schemes by retaining the present waiver authority. We would strongly support allowing states and communities to continue to move to payment systems which differ from Medicare, as long as it can be demonstrated that total Medicare expenditures do not exceed what they would have been under the national system.

Overall, the Secretary of Health and Human Services' report on prospective payment is a constructive beginning toward restructuring the Medicare payment program. The Administration's proposal shifts the focus of payment incentives away from hospital processes toward hospital outputs, that is, cases of treatment. In theory, these incentives could motivate hospitals to examine the cost-effectiveness of how they deliver care and how they consume resources in the process. We favor these kinds of incentives. However, as might be expected, given the tight deadline, the report is more an outline than a definitive blueprint for reform. Before such a major change is made in the program, much more study and information is needed on several important issues, including:

What will be the impact of the proposed changes on various types of hospitals, such as teaching institutions, public hospitals and small hospitals?

What will be the longer term impact on beneficiaries' access to hospital services? (That is, will the proposed system inevitably evolve into an indemnity program which requires substantial beneficiary out-of-pocket expenditures?)

Since any system can be manipulated, where is the proposed system vulnerable and, if the incentive cannot be improved, what counter measures are needed?

What key technical points need to be spelled out in a legislative proposal now so that we can better assess the impact of and plan the implementation of a new program?

In summary, it is our opinion that it will take time to evaluate this proposal adequately and to determine whether it is, on balance, better the present system. Perhaps the Diagnosis Related Groups (DRG) approach will stand the test of this evaluation; perhaps it will not. In any case, we do not believe that the Congress should rush to enact an incompletely evaluated proposal. And, certainly, we do not believe an October 1983 implementation date is realistic. Medicare Intermediaries still have not yet implemented the changes required under TEFRA for all hospitals and some hospitals will not come under these new limits until September of this year. Such major changes in such a short period of time might seriously disrupt the hospital industry.

For these reasons, we recommend that the Medicare payment changes that were adopted last year should be continued for the time being. We are aware of the limitations and the hazards of these changes, and we urge you to consider relaxation of the Section 223 limits to reduce the potential adverse consequences. We are particularly concerned about the potential impact on "sole source," inner-city and teaching hospitals.

In the remainder of this testimony, we would like to do two things:

1. Outline what we believe the critical objectives for a Medicare payment system to be; and
2. Discuss some of the major strengths and weaknesses of the Administration's proposal.

PAYMENT SYSTEM OBJECTIVES

For Medicare, as for private payors, payment systems should serve several objectives. These include:

Assurance of the beneficiary's continued access to needed care;

Maintenance of a quality health care system;

Cost-effective management of health care resources with rewards for efficiency and penalties for inefficiency;

Predictabliity of the amount and timing of payment for both beneficiaries and providers;

Sensitivity to differences in individual hospital's and community's legitimate needs;

Administrative economy and feasibility;

Program requirements and processes that both receivers and providers of care can accept as understandable and reasonable;

Control on excess capacity; and Protection against hospitals surcharging patients.

Clearly some of these objectives can be in conflict with each other. Predictability and administrative feasibility can be at odds with sensitivity to community and institutional needs. Cost control incentives may jeopardize quality and access to care if they are pursued too zealously. We recognize that tradeoffs have to be considered and reasonable compromises reached.

The Administration has recognized most of the objectives outlined above. However, it is not yet clear that its optimism about how well the proposed approach will succeed in meeting these goals is justified.

COMMENTS ON THE ADMINISTRATION'S PROPOSAL

We are still evaluating the Administration's proposal and would like much more information about the data and assumptions on which it is based. Still, our reading indicates that the proposed system has a number of promising features:

It attempts to assure predictability in the level of government payments to hospitals.

It should help hospitals manage their resources more effectively and in a manner consistent with their expected Medicare payments.

It provides rewards for efficiency (but may also reward hospitals that have below average costs for reasons other than efficiency).

It may require no new data for its operation, although some new data may be required for more effective monitoring of admissions and quality.

It may recognize case-mix problems more adequately than TEFRA.

These advantages are significant but need to be viewed in the context of potential weaknesses. No payment system is perfect, and any system has inherent incentives that hospitals will naturally respond to but which may not be in the best interest of the program. We need to identify the undesirable incentives in the proposal and the modifications that might be made in response. Although our analysis is not yet exhaustive, we want to indicate a few of the problems we see.

Impact on hospitals of a national average DRG price

We are concerned that paying hospitals on the basis of a nationally determined average price could seriously harm some hospitals, even after regional wage adjustments are made. The "average price" will be more than adequate for some hospitals and will be less than adequate for others. Some hospitals with costs which are lower than the national price may not necessarily be efficient; however, they will be rewarded under this system. Other hospitals may be penalized, not because they are inefficient, but because they have special circumstances that the proposed payment method does not take into account. We are concerned that some of the most severely affected hospitals may be essential community institutions, and we would like to see data that assures us that the proposal reflects sufficient sensitivity to justifiable variations in hospital and community circumstances.

Although we favor incentives that will move hospitals to greater efficiency, inefficiency cannot be corrected overnight. For that reason and because of our concern regarding local needs, we believe the Congres should consider use of a transition period if a prospective payment system based on national rates is adopted. Hospital-specific DRG rates could be used initially and the uniform national rates gradually phased in. This would give hospitals time to plan and implement constructive management changes that are responsive to the incentives of the new program. A phased-in approach would also reduce the risk of serious and inappropriate disruption in the provision of hospital care to Medicare beneficiaries.

Arbitrariness of determining the national average price

While the Medicare reasonable cost methodology in recent years did employ increasingly stringent limits, there has always been an underlying principle that the reasonable cost of providing services to Medicare beneficiaries would be covered. Such a principle has enabled the program to hold to the rule that hospitals cannot charge beneficiaries for any out-of-pocket amounts for covered services (other than deductibles and coinsurance amounts).

We strongly support the program continuing to hold to the principle of no patient "surcharging." We believe it is the most fundamental protection of beneficiaries against otherwise uncontrollable out-of-pocket medical care costs.

It must be recognized, however, that the yearly calculation of an "average" price per admission may be extremely vulnerable to Federal budgetary pressures and may become subject to continuing and arbitrary "squeezing." If this is the case, hospitals may eventually have a strong argument for billing patients for the balance of unrecovered costs. The vulnerability to manipulation of the average price will depend, to a great extend, on how completely any legislation spells out the methodology for calculation of the price, the methodology for the yearly update of the price, and the machanism for assuring accountability of the reasonableness of the price.

Incentives for hospitals to increase payments by manipulating case load

Except for a comprehensive capitation payment system or a flat limit on hospital revenues, almost any payment method will tend to stimulate production of whatever unit the payment is based on, whether it be individual services, days of care, or cases. Although the DRG approach contains incentives that could reduce the average length of stay for inpatients and the intensity of the services provided, it could stimulate an increase in the number of admissions. In particular, hospitals could profit by increasing the volume of low costs admissions. This would run counter to existing efforts of third party payers to encourage the use of the outpatient care for relatively simple cases, and could ultimately have an undersirable effect on cost and quality of care.

The Administration's proposal recognizes needs for safeguards against inappropriate admission increases, but the process it offers is neither well defined or proven in use. A number of promising methods for monitoring and controlling inappropriate hospital admissions are now being evaluated around the country, but their cost effectiveness and feasibility and Medicare is not clear at this time. But what is clear is that the government should not proceed with a per case program until it has better evidence that in can implement reliable and cost effective utilization controls and quality assurance systems. To work properly, such systems will have to have adequate funding.

Incentives for hospitals service "unbundling"

Of major concern to us is the inherent incentive for hospitals to accelerate the already alarming trend of what we call "unbundling." That is, hospitals are increasingly billing patients directly for ancillary services (radiology, pathology, therapy) which were formerly included in the hospital bill and reimbursed on a cost basis. Hospitals and physicians can do this by the hospital leasing space in the institution to physicians who then bill patients directly for services under Part B of Medicare. Alternatively, hospitals may transport patients or specimens to be tested to an adjacent office building where the service is provided to inpatients as an outpatient service and billed accordingly.

We see the practice as most unproductive. First, patients, when billed directly, must pay the 20 percent coinsurance and face all the attendant problems of the physician refusing to accept assignment. Second, the movement of the place of service leads to unproductive use of existing hospital capital and generates more capital (outpatient) expenditures.

This unbundling phenomenon has major implications for almost any prospective system. If the trend accelerates, or even just continues, the package of services the DRG-fixed rate of payment is actually purchasing may not look at all like the package of services that hospitals provided when the rate was initially calculated. The Medicare program could end up paying twice for services; once under the DRG rate as an al inclusive inpatient service and under Part B as an outpatient service.

We would further note that these incentives could lead to changes which cannot be "backed away from" through future corrections in the payment system. They are fundamental changes in the way we deliver health care services involving major capital commitments which obligate the delivery system to long-term financing costs.

Incentives for excessive capital investment

We are also concerned about the effect of the capital pass-through under the Administration's proposal. Many see capital investment as driving health care costs. Moreover, capital costs comprise a significant portion of current payments to hospitals and this should not be overlooked.

We do not want a payment approach that encourages investment that leads to unneeded use of services. Nor do we want a method that promotes competitive capital investment without regard for total community resource needs.

We wish to stress that our concern with the capital issue is broader than the amount added directly to the payment rate. Capital expenditures today generate operating costs tomorrow. It has been argued that increased operating costs associated with new capital will not be "passed through" in the DRG rate. Hospitals, however, can recover these new operating costs to the extend that they can increase the volume of cases.

We recognize that the Administration is concerned about excluding capital costs from the per case payment. As one safeguard, we believe that continued federal support for health planning is important to help counterbalance potential incentives for both facility expansion and inequitable resource distribution.

Incentives affecting the quality of care

Under retrospective reimbursement we have experienced incentives for excessive care; under prospective payment we may provide incentives for insufficient care through premature discharge, inadequate testing, and other shortcuts. The professional instincts of hospitals and medical staffs well go a long way to safeguard the quality of care. However, tensions will arise over the limitations of price for those cases which cost the hospital more than allowed for under the DRG payment. This needs to be understood and represents another reason to base the DRG payment, at least in the initial years, on an institution's own cost experience.

Some of the issues discussed above are considered in the Administration's report. However, the report seems to us to be overly optimistic about the quality of current evidence and its own analysis on these issues. We believe the Administration should share with the public the information, estimates and models that it has used in developing the payment proposal. This would permit more extensive and objective evaluation of the proposed system. We need, in particular, a much better sense of which hospitals will be adversely affected and to what extent.

Incentives affecting technological and service innovation

Although the proposed system might stimulate innovations that reduce costs and slow the premature spread of inadequately tested technologies, it might have negative effects as well. In particular, it could discourage investments and stifle innovations that would improve health status at initially higher cost. Under a prospective system, Medicare might need a mechanism to identify and pay for technologies that could be discouraged despite legitimate need because payments were not adequate to encourage investments in their development.

ADMINISTRATIVE AND TECHNICAL CONSIDERATIONS

The successful implementation of this proposal (as with any other payment system) will rest on technical details and the skills of the Intermediary. As it stands, the specific provisions necessary to understand fully the operation and impact of the proposed system are not sufficiently defined in the Administration's report. For example, a hospital's revenue would vary significantly depending on the mathematical calculation used to determine the national average price; however, the proposal is deliberately silent about the approach that will be taken. If the determination of the price is totally unaddressed in legislation, calculation of the national average price would become dependent on an arbitrary decision of the Administration.

Another unknown is how "outliers" (that is, very long-stay cases) will be identified and paid for. The definition of "outliers" and how they are reimbursed may have a major impact on the distribution of revenue to various kinds of hospitals.

Clarification is also needed concerning reconciliation of existing beneficiary coverage limitations with case-based payment For instance, we do not know whether the patient who exceeds current program limits on days of care would be billed for the balance of his stay or whether the case payment approach contemplates full payment regardless of benefit period.

In addition, the Administration's proposal does not indicate what types of exceptions and adjustments would be granted to sole community providers. Nor is it clear that the proposal deals adequately with the unique problems of small hospitals. These hospitals often have a small number or no cases of a given type in one year and larger numbers in the next; this wide swing in case-mix is likely to result in wide swings in revenue which may have little to do with efficiency.

Although one objective of the Administration's proposal is simplified hospital reporting requirements, we question how much simplification can be achieved. Costs will still have to be determined for capital and medical education, and overhead will still have to be apportioned to support reasonable cost payments for outpatient and certain other hospital-based providers (home health agencies and skilled nursing facilities). In addition, the utilization and quality monitoring functions alluded to in the Administration's report will depend on data collection. Obviously, substantial reporting requirements will still be necessary.

Finally, the transition to any new system is a major undertaking. The current TEFRA regulations are effective for hospital accounting periods beginning on or after October 1, 1982. The proposed DRG system is to replace the current system and to become effective at the beginning of hospitals' accounting periods on or after October 1, 1983. This schedule means an unprecedented and intensive workload if the Intermediary, the Health Care Financing Administration and hospitals are to meet the educational and implementation tasks associated with both the current and the proposed system. This is a major practical drawback to the Administration's proposal. It is also important to note that this demanding transition will require that adequate resources be budgeted for it.

CONCLUSIONS AND DIRECTIONS

To summarize, we believe the Administration has taken a constructive step toward the development of incentives for cost effective management of health care resources. However, adoption of its proposed payment system in its current state of development would be premature. There are two bases for this conclusion.

First, many serious questions still exist about how the proposed incentives would affect total Medicare expenditures, quality, beneficiary access, and community resource allocation. The Medicare program has multiple objectives that must be kept in mind as we assess reform of its payment system. There is a pressing need for more conceptual development, more data, more modeling of effects, and more evaluation of TEFRA's impact. The time needed to do this work properly and to make appropriate modifications should not be underestimated.

Second, major changes in Medicare payment policy were made just last summer. It is not prudent to make another major change in the program so soon.

For these reasons, we believe the Congress should not rush to approve the Administration's proposal without thorough evaluation and that implementation this Fall would be precipitous. Given this recommendation against immediate change, we must again cite our concern with TEFRA's payment limits and suggest that you consider the effects that these limits may have on key hospitals and their patients.

Again, we appreciate the opportunity to present our views.

STATEMENT OF RANDY A. FREUDIG, PRESIDENT-ELECT, AND CHAIRMAN, COST SHIFTING COMMITTEE, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

Mr. **Freudig**. Mr. Chairman, my name is Randy A. Freudig. I am here as spokesman for the National Association of Health Underwriters which was founded in 1930 to represent the interests of the health insurance sales agents and the public which they serve.

I am a health insurance agent specializing in health insurance coverage for many years. I own and operate my own agency, R. A. Freudig Associates in Warrington, Pa. Our agency serves over 2,000 insured with 3,000 dependents which means that over 5,000 Americans have their health insurance through my office.

A hospital prospective payment system is an idea whose time has come. We cannot support this particular proposal unless and until all other third-party payers are to be treated in the same manner as medicare and medicaid.

We want medicare and medicaid to pay the same prospective payment for hospital care that the hospital would charge a private patient.

We want our insurance companies, Blue Cross, HMO's, and all other third-party payers [illegible] billed on that very same prospective payment basis.

We urge the committee [illegible] establish a new doctrine of fairness for the good of all who pay [illegible] bills and that this doctrine of fairness be an essential part [illegible] equally necessary hospital prospective payment system.

By adopting a new doctrine of fairness in the hospital payment system, the Congress will eliminate the root cause of the current dilemma which is called hospital cost shifting.

The public's dilemma is that we must ask them to pay $5 in premiums for every $4 of hospital insurance because the hospital cost shifts to them an extra 25-percent or so as a hidden surcharge. This hidden surcharge has been created by the hospital because medicare and medicaid have embarked on an unfair practice of underpaying the hospital bills that they are responsible for.

Because of cost shifting, I have had the unpleasant experience of having to take to my clients notices of sizable increases in their health insurance premiums. Increases far in excess of inflation, sometimes as high as 65 percent; so high some insureds have been forced to drop their coverage and risk going without any insurance at all.

They need a doctrine of fairness in the hospital prospective payment system.

Because of cost shifting, I have had insurance companies notify me that they decided to discontinue the sale of their products. Today we have, to represent to the people, less than 100 companies that write comprehensive hospital and major medical coverage. In the 1960's there were over 600.

A doctrine of fairness in the hospital prospective payment system would bring many of these companies back to the competitive arena for the benefit of the public. If a hospital prospective payment system becomes law without the inclusion of a doctrine of fairness to all payers, more insurance companies will be under pressure to abandon a business in which they are forced to charge the public a 25-percent hidden tax for their hospital insurance.

The public interest would be ill served by a law which would deny the citizen a wide variety of competitive health insurance plans from which to choose.

Because we believe that it is patently unfair for the U.S. Government to force, albeit indirectly, the health insurance agents to collect $6 billion in medicare/medicaid underpayments to hospitals, manifested in hospital cost shifts to our insureds, the National Association of Health Underwriters has released a public message on video tape, film and slides entitled "Cost Shifting—Your $6 Billion Burden."

The script of this presentation is submitted for the record.

NAHU cordially invites Members of Congress and their staffs to view a video tape of "Cost Shifting—Your $6 Billion Burden" at their convenience on Capitol Hill. Arrangements can be made by calling Robert Allen, NAHU chairman for government affairs, (202) 546-4609.

Mr. Chairman, I would like to conclude this statement with the three recommendations the NAHU film presentation makes "To Get That Hidden Tax Burden off the Public's Back"?

Establish a Presidential commission to study health care payment reform and make recommendations to Congress within 1 year.

Establish a State Governor's commission to study health care payment reform and make recommendations to your State legislators and insurance regulators.

Establish a State prospective payment system permitting all payers to reimburse hospitals on an equitable basis. A prospective payment system would provide that medicare, medicaid, Blue Cross, HMOs, insurance companies, and self-paying patients would all pay the same money for the same services.

I thank you for the opportunity to present our views.

[The prepared statement follows:]

STATEMENT OF RANDY A. FREUDIG, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

Mr. Chairman, my name is Randy A. Freudig and I am here today as spokesman for the National Association of Health Underwriters. NAHU was founded in 1930, to represent the interests of the health insurance sales agent and to establish and maintain high standards of ethical business practice and continuing education for the purpose of providing the public with health and disability insurance coverage.

I am, and have been, a health insurance agent specializing in health insurance coverage for many years. I own and operate my own agency, R. A. Freudig and Associates, in Warrington, Pennsylvania. Our agency serves over 2,000 insureds, who have approximately 3,000 dependents, which means that over 5,000 Americans have their health insurance through my office.

On behalf of the over 5,000 members of the NAHU and the 2,000 who have earned the designation of registered health underwriter (RHU), I am honored to be given this opportunity to express the views of the health insurance field agent on the subject of the hospital prospective payment system proposed by the Department of Health and Human Services.

A hospital prospective payment system is an idea whose time has come. But we cannot support this particular proposal unless, and until, all other third party payors are to be treated in the same manner as medicare and medicaid. We respectfully urge the committee to recognize our dilemma and the dilemma of the private health insurance companies in supplying us with the health insurance products with which we serve the health insurance needs of the American people.

We want medicare and medicaid to pay the same prospective payment for hospital care that the hospital would charge a private patient. Accordingly, we want our insurance companies to be billed the very same prospective payment. And we want Blue Cross, HMO's and all other third party payors to be billed on that very same prospective payment basis.

We urge the committee to establish a new doctrine of fairness for the good of all who pay hosptial bills and that this doctrine of fairness be promulgated as an essential part of an equally necessary hospital propsective payment system.

By adopting a new doctrine of fairness in hospital payment systems the Congress would eradicate the root cause of the current dilemma which we share with that segment of the American public to whom we market health insurance coverage. The root cause is hosptial cost shifting.

The public's dilemma, which the insurance agent shares, is that we must ask them to pay $5.00 in premium for every $4.00 of hospital insurance coverage because the hospital cost shifts to them an extra 25 percent or so as a hiden surcharge. This hidden surcharge, amounting to hundreds of dollars per year in health insurance premiums to the average American family we insure, has been created by the hospitals because medicare and medicaid have embarked on the unfair practice of underpaying the hospital bills that they are responsible for.

Because of cost shifting, I have had the unpleasant experience of having to take to my clients notices of sizeable increases in their health insurance premiums. Increases far in excess of inflation, sometimes as high as 65 percent; so high that some insureds have been forced to drop their coverage and risk going without any insurance at all. They need a doctrine of fairness in the hospital prospective payment system.

Because of cost shifting, I have had insurance companies notify me that due to the increasing high prices of medical care, they decided to discontinue the sale of their products. Today, we agents have, to represent to the people, less than 100 life and casualty companies that write comprehensive hospital and major medical coverage whereas there were over 600 in the 1960's. Not all of these companies sell their products in all states. A doctrine of fairness in the hospital prospective payment system would bring many of these companies back to the competitive arena for the benefit of the public.

But, on the other hand, if a hospital prospective payment system becomes law without the inclusion of a doctrine of fairness to all private payors, more insurance companies will be under pressure to abandon a business in which they are forced to charge the public a 25 percent hidden tax for their hospital insurance. The public interest would be ill served by a law which would deny a citizen a wide variety of competitive health insurance plans from which to choose.

Because we believe that it is patently unfair for the U.S. Government to force, albeit indirectly, the health insurance agents to collect $6 billion in medicare/medicaid underpayments to hospitals, manifested in hospital cost shifts to our insureds, the National Association of Health Underwriters has released a public message on video tape, film and slides entitled: "Cost Shifting—Your $6 Billion Burden."

The Script of this presentation is submitted for the record. It identifies a number of additional distortions caused by cost shifting which are contrary to the interests of the American people. For example: up to 35 percent of automobile insurance and workers' compensation premiums are used to cover health care costs and do not escape the negative impact of cost shifting. Another example: Some hospitals have so few private patients they can't shift the cost and will eventually go bankrupt.

NAHU cordially invites Members of Congress and their staffs to view a video-tape of "cost shifting—your $6 billion burden" at their convenience on Capitol Hill. Arrangements can be made by calling Robert Allen, NAHU chairman for government affairs, 202-546-4609.

Mr. Chairman, I would like to conclude this statement with the three recommendations the NAHU film presentation makes "to get that hidden tax burden off the public's back":

Establish a Presidential commission to study health care payment reform and make recommendations to congress within one year.

Establish a State Governor's commission to study health care payment reform and make recommendations to your State legislators and insurance regulators.

Establish a State prospective payment system permitting all payors to reimburse hospitals on an equitable basis. A prospective payment system would provide that medicare, medicaid, blue cross, HMO's, insurance companies and self-paying patients would all pay the same money for the same services.

[Addendum]

COST SHIFTING—YOUR $6 BILLION BURDEN

Script for the Video Tape—Film—Slide Presentation being distributed throughout the country by the National Association of Health Underwriters for, the purpose of educating the public to the horrendous practice of hospital cost shifting which results in private patients (including those with private health insurance) being billed more than the cost of their own hospital stays, in order to make up for the below cost discounts that hospitals must give to Medicare and Medicaid patients, and further, to make up for the discounts that hospitals give to some Blue Cross plans, and some HMO's.

NAHU charges that this Medicare/Medicaid Cost Shift to private paying patients alone amounts to a hidden tax of $6 billion, and NAHU urges to the public to register with their Congressmen and Senators their oppostion to this Cost Shifting before it is allowed to destroy the great American system of health insurance.

For more information, contact: National Association of Health Underwriters, 145 North Avenue, Hartland, Wis. 53029; 414/367-3248.

SCRIPT FOR COST SHIFTING SLIDE PRESENTATION

Slide No. and subject:

1. Blank slide on music.

2. National Association of Health Underwriters presents.

3. Cost shifting your $6 billion dollar burden.

4. Randy Freudig sitting at office desk: Hello, I am Randy Freudig, Chairman of the committee on cost shifting of the National Association of Health Underwriters.

5. Freudig: As a personal producing general insurance agent, I write all types of insurance.

6. Freudig: I believe that my agency, which is located in Warrington, Pennsylvania, is typical of many thousands of agencies in cities and towns throughout our country.

7. Freudig: Thousands of people are insured through my agency for their hospital and major medical coverages.

8. Patient being treated by nurse: When my clients become ill, or injured, they rely on their insurance coverage for the payment of the major portion of their doctor and hospital bills.

9. Freudig: Over the last few years, I have had the unpleasant experience of having to take to my clients notices of sizable increases.

10. Freudig: Increases far in excess of inflation, sometimes as high as 65 percent; so high that some insureds have been forced to drop their coverages and risk going without any insurance at all.

11. Dollar signs—health insurance premiums: I have had insurance companies notify me that because of the increasing high prices of medical care.

12. Freudig: They decided to discontinue the sale of their products. There has been a drastic reduction of the number of companies still writing comprehensive hospitalization and major medical coverages.

13. Freudig: Calls come to me daily from agents and brokers all over America. Their concern is that they are looking for new markets.

14. Freudig: Their fear is that with the loss of these markets their clients financial stability is threatened due to

15. Cost shifting, your $6 billion dollar burden: The problem term * * * cost shifting. Music.

16. Woman reading newspaper: Good lord, honey, would you

17. Woman to husband in bkgnd: look at this. Our health insurance

18. Woman to husband: has gone up again. Why?
19. Woman, Why does it seem like it's going
20. Woman: up faster than anything else?
21. Employer: This is the second premium increase we've had in our health insurance this year and only 1 claim in 10 employees.
22. Employer: What's causing it? And when in blazes is it going to end?
23. Spilit of above two: **Narrator**. Your health insurance premiums continue to go up, beyond inflation, because of an unfair government practice that is called
24. Cost shifting: Cost shifting. It's big burden. In fact, it's . . . your $6 billion burden. Music: Opening title.
25. * * * your six-billion dollar burden. Let's examine this critical problem.
26. Hospital: A hospital cares for people from all backgrounds—
27. Nurse with patient: People insured through insurance companies,
28. Nurse with patients: Blue Cross, and through health maintenance organizations, (HMO's).
29. Emergency room: as well as self-paying patients. In addition,
30. Emergency room: the hospital cares for poor Medicaid patients and elderly Medicare patients.
31. Scenes from hospital's accounting section. Bills: But, here's the problem.
32. And prescription charges being processed, charges being added up on an adding: The Federal government, some Blue Cross plans, and some HMO's,
33. Machine, etc. don't pay the full cost of caring for their patients in a hospital.
34. Employer: You mean the government doesn't pay for Medicare and Medicaid patients?
35. Nurse with patient: **Narrator**. Oh, it pays for them.
36. Doctor with patient: It just doesn't pay the full amount of what it costs hospitals to
37. Ambulance: Treat those patients. Because the government has arbitrarily ruled that it will only pay
38. Direct patient care: for what it calls "direct patient care costs."
39. Woman: **Woman**. What does that mean?
40. Itemized hospital bill: **Narrator**. It means that the government will reinburse hospitals for their out-of-pocket expenses for providing services to patients * * *
41. Pharmacy scence: room and board, nursing and hospital services, medication, laboratory services.
42. That's what it calls "direct patient care costs". . .
43. and it doesn't even reimburse 100 percent but only about 80 percent of these costs.
44. Series of hospital pictures: The government won't pay its fair share of the hospital's capital expenditures
45. for items such as new equipment for improved patient care or building expenses.
46. It also won't reimburse the hospital for normal
47. costs of doing business.
48. such every day things as bad debt expenses
49. and telephone costs. It's as though you as a manufacturer were allowed to charge customers for
50. materials and labor costs
51. of producing your product, not for
52. Listing of following expense items, plant maintenance, repairs, new equipment, bad debts, etc.: capital expenditures, bad debts, or many of the other things you normally include in your costs.
53. Employer: How much does the government avoid of what it should pay?
54. Dollar bill: **Narrator**. It varies from state to state and hospital to hospital. But, a fair estimate is that the government usually pays a hospital
55. Scissors cutting away 40 percent of the dollar, to indicate shortfall in Government payment: only about 60 cents for each dollar it's billed.
56. No hospital can survive: And since no hospital can survive for long by taking in less money than it spends on patient care
57. Hospital photo: hospitals have to shift those unpaid costs for Medicare and Medicaid patients to other patients.
58. Woman: Other patients? You mean, patients like me?
59. Graphic representation of cost shifting. Privately insured Patients: **Narrator**. Right. If you're insured by a private insurance company, or paying your hospital bills yourself
60. With money patients to medicare/medicaid patients: twenty-five percent of your bill goes to

61. pay cost of Medicare and Medicaid patients.

62. Show Govt. grouped in third area of screen with money flowing from privately insured patients to Govt.: You see, the government has committed itself to provide more benefits for Medicare and Medicaid patients than it can offer to pay for so it shifts those costs onto us . . .

63. $6 billion: Nearly $6 billion this year alone—and growing, particularly with federal budget cutbacks.

64. Cost shifting: If you wonder why your premiums are going up, it's to make up the difference caused by cost shifting.

65. Woman: It almost seems like a form of hidden taxation.

66. Show taxpayer with money bleeding from both pockets: NARRATOR. It's even worse. At least, if it were a tax, everyone would pay the same tax. But a small select group of people are forced to make up to hospitals for the government payment shortfall.

67. Employer: And we're in that select group, huh?

68. Show taxpayer now with more money flowing from one pocket than the other: NARRATOR. Yes, if you're a self-pay patient, or if you're insured by a private insurance company,

69. Blue Cross logo: or if you're insured by a Blue Cross plan that pays its fair share, you're paying for the other patients. In many hospitals, half of the patients are paying for the other half.

70. Employer: Hey, that's not right!

71. Woman: I thought you said something about Blue Cross plans. They pay their fair share of a hospital bill, don't they?

72. Blue Cross Discount: NARRATOR. About two-thirds of the Blue Cross plans pay their fair share and receive a discount of at most one to two percent. The other third of the Blue Cross plans receive huge discounts of ten to 35 percent. That means an even heavier burden for you as the client of a private insurance company.

73. Woman: Any you said the burden is * * *

74. Show taxpayer with bulging money sack on this back: NARRATOR. Almost 6 billion dollars. That's the difference between what you pay this year for health insurance and the underpayment by government. And in states.

75. Blue Cross Discount: where Blue Cross is getting a sizeable discount,

76. Cost shifting: you're paying an even heavier cost shift burden.

77. Woman: No wonder my premiums go up so often.

78. Negative effects of cost shifting: NARRATOR. Yes, that's a major reason for increases in health insurance premiums. But cost shifting has some other side effects you should know about.

79. Cost containment: You've probably read about the importance of cost containment in keeping medical cost down.

80. Hospitals photos: This means that hospitals are being encouraged to treat patients in a more efficient manner to prevent medical costs from rising at such a rapid rate.

81. Cost shifting: Cost shifting defeats the whole purpose of cost containment because the more hospitals spend, the more they are paid by the government.

82. Hospital bill being inflated with an air pump so it looks like a balloon: When the government doesn't pay, you do. This defeats efforts to keep costs at a reasonable level.

83. Cost shifting negative effects: Here's another drawback of cost shifting. Some hospitals have so few private patients, they can't shift the costs.

84. Hospital bankrupt: When these hospitals take in less money than it costs to treat patients, they wind up with deficits and could eventually go bankrupt.

85. Employer: That means that hospitals could close, right?

86. Poor and elderly people waiting to be cared for in a large inner city hospital: NARRATOR. Yes, and this is particularly true of the larger public and inner city hospitals but could occur to any hospital which is often the only source of care for the poor and the elderly, and if these go under, there will be further cost shifting.

87. Show garden with several flowers. Each labeled "Health Insurance Company". several of the flowers are being strangled, and only two remain healthy-looking: Cost shifting can also have an impact on the number of insurance companies offering health insurnace. As private insurers raise their premiums to accommodate cost shifting, many of them can't continue to compete to meet your needs. This means fewer choices for consumers. In fact,

88. Mid 60's over 600: since the federal government became directly involved in Medicare and Medicaid in 1965,

89. Mid 60's over 600 less than 100: the number of health insurance companies has dropped from over 600 then to less than 100 today. This means there are fewer choices, and eventually it could result in no choice of health insurers.

90. Hospital costs inflating costs for auto and workers' compensation: Cost shifting has affected all insurance costs, including automobile insurance where 15 to 20 percent of your premimum goes for health care costs and Workers' Compensation.

91. Graph showing escalating premiums for health insurance: where 30 to 35 percent of your premium goes to health care. So all insurance premiums are rising at an alarming rate.

92. Two shot, employer and employee looking puzzled: WOMAN. So what's the answer? How do we get this six billion dollar burden off our backs?

EMPLOYER. Look, why doesn't the government stop trying to provide more benefits than it can afford to pay for?

93. Long shot of Capitol Building in Washington: NARRATOR. Because in the current political climate, Washington is more interested in cutting its share of social welfare costs than it is in keeping past promises.

94. Capitol: A movement at the federal level to increase financial responsibility would very likely fall on deaf ears.

95. Employer: Well, how about Blue Cross and HMO's? Why don't hospitals just stop giving any discounts?

96. Blue Cross discount applied for: NARRATOR. Many hospitals are reluctant to jeopardize their relationships with Blue Cross and HMO's.

97. Blue Cross discount "Granted": Hospitals have been forced by Medicare and Medicaid to cost shift. But, hospitals are beginning to realize that all payors must pay the same fees for the same services; discounts just don't work.

98. Woman: Well, what can be done?

99. Hidden tax: NARRATOR. To get that "hidden tax" burden off your backs, work must be done at the

100. Capitol: federal and state levels. You have to put pressure on your congressional and state law makers and insureance regulators to tackle your problem of cost shifting.

101. Establish a Presidential Commission to study healthcare payment reform and make recommendations to Congress within one year. Establish a State Governor's Commission to study healthcare payment reform and make recommendations to your state legislators and insurance regulators. Establish a state prospective payment system permitting all payors to reimburse hospitals on an equitable basis. A prospective payment system would provide that Medicare, Medicaid, Blue Cross, HMOs, insurance companies and self-paying patients would all pay the same money for the same services.

102. Woman: Sounds good. But what about states where Blue Cross receives sizeable discounts?

103. Blue Cross Discount: NARRATOR. In states where Blue Cross receives from 10 percent to 35 percent discounts, such as New York, Pennsylvania, Alabama, and Connecticut.

That state needs legislation calling for all payors to pay on an equitable basis with all other payors. This legislation would require Blue Cross, HMOs to pay the same billed charges as private insurance companies and self-paying patients.

104. Employer: So what you're doing is legislating fairness, right?

105. If any hospital offers a discount, that same discount must be offered to anyone who can meet the conditions and the offer: NARRATOR: Yes. Such a law would stipulate that if a hospital offers a discount to anyone who pays, it must offer that same discount to anyone else who wants the discount and who can meet the conditions for the discount.

106. Woman: So what you're saying is that any person or group who pays for health care costs should be entitled to the same prices for the same services.

107. Cost shifting: NARRATOR. Yes. Now let's see how this applies to you. What is cost shifting really doing to *you*?

108. Family: Well, if you have a family of four, there's one chance in ten that someone in your family will be hospitalized during the next year. Your projected stay? An average six to eight days.

109. Itemized hospital bill total $3,000: On the average, this may cost about three thousand dollars. But, because of cost shifting,

110. Itemized hospital bill totalling $4,000: your actual bill will be about $4,000. In other words, about one quarter of your bill goes to pay for Midicare and Medicaid patients. That means you'd pay

111. Total $1,000: or your insurance carrier would pay on you behalf, a thousand dollars for someone the government should be paying for.

112. Employer-Employee Group: Let's say you're an employer. What does cost shifting mean to you. For example, if you have 10 employees,

113. Hidden tax: you will pay about three thousand dollars extra in hidden tax premiums every year.

114. Hospital marked "closed": Think what else cost shifting could mean to you. A hospital closed up tight when you need one most.

115. Insurance application form stamped "Application denied". Only one or two insurance companies that would write health insurance for you. If Company A won't insure you, then you'd have to go to Company B.

116. Dollar signs showing health insurance premiums rising: And, most immediately, cost shifting means health insurance premiums climbing higher and higher each year. The only way to slow down the rise in insurance premiums is to stop cost shifting!

117. Woman: He's right! That is important!

118. Man: EMPLOYER. We've got to do something!

119. Hand lifts $6 billion burden from crushed figure: NARRATOR. When all is said and done, only prompt, effective action will free you and millions of other policyholders and employers from the double burden of health care. Join with us at the neighborhood level for action.

120. Folder on cost shifting: You can make your voice heard by signing your action card and sending it to your lawmakers.

121. "Signature by" written on action card: Tell your congressional and state legislators and regulators they must set you free—

122. Cost shifting—your $6 billion burden from cost shifting—your six billion dollar burden! MUSIC

123. Randy Freudig sitting on edge of desk: You now know about . . . . cost shifting and how . . . hidden taxes . . . are being used to finance the Medicare and Medicaid programs.

124. Freudig: We insurance agents and home office underwriters believe in our country's free enterprise system and open competition.

125. Freudig: We are opposed to cost shifting. Hospital trustees, administrators and controllers are also opposed to this form of hidden taxation. Now that you have a better understanding about cost shifting . . . I hope you will express your opposition to your legislative leaders and your state insurance regulators.

126. Freudig: You can do this by completing the card you will recieve at the end of this program. We ask you to mail this card to our Washington office. Thank you.

127. NAHU logo—music.

128. Credit

129. Black slide; music end.

Chairman JACOBS. I must say I have heard a lot of lawyers influence Members of Congress by all kinds of things. This is probably the first case of an offer of free movies.

Mr. Shannon.

Mr. SHANNON. Mr. Freudig, I appreciate your testimony. I think you raise some issues that some of us are concerned about.

Do you think a Presidential commission is the answer to this problem?

It seems to me that we have to deal with this issue quickly. The testimony we have heard about the state of the medicare trust fund, and regarding what is happening to health costs generally, shows that we have a more immediate problem.

I am wondering whether or not you think the delay involved in establishing a Presidential commission is really warranted at this time?

Mr. FREUDIG. I would not like to see a long delay by a commission studying this problem. I think we know most of the answers already. I would not like to see a Presidential commission dragging on and on. We know what the problem is. We have to solve it immediately.

Mr. SHANNON. What about the States that have waivers now? How is that working as far as you see it?

Mr. FREUDIG. From where I sit and I see it in the field, we see some light at the end of the tunnel with those States using the waiver system. If the light at the end of the tunnel is there for them, then certainly it should be for every other State that does not have it.

Mr. SHANNON. You are urging the same system that applies to the States that have waivers should be applied nationally?

Mr. FREUDIG. That is right.

Mr. SHANNON. What delay is involved in doing that? Is that the bottom line for you?

Mr. FREUDIG. Until we have a fairness doctrine, and I am using that as probably another title, to bring everyone in line so that we are all paying equally, we are really not going to solve this problem. That has to be a step that must be accomplished.

Mr. SHANNON. You have studied that and come to that conclusion?

Mr. FREUDIG. I have come to that conclusion. Otherwise, it is cost shifting and you don't solve it.

Mr. SHANNON. I don't have any further questions.

Chairman JACOBS. Mr. Moore.

Mr. MOORE. Thank you, Mr. Chairman.

Mr. Tresnowski, I assume the Blues are victims of cost shifting?

Mr. TRESNOWSKI. Not really. We think the cost shifting argument is overstated. We think that it misses the point of contract payment for care which is the way the medicare program pays and the way Blue Cross pays generally. That is the way HMO's are paying.

The latest phenomenon crossing this country is the notion of provider option which in effect says the contractor goes to a provider and says, "Will you provide health care for a negotiated price?"

The provider is not bound to that. He agrees voluntarily to sign that contract. That contract negotiated price is based on a legitimate and fair payment for the services received.

The notion of cost shifting that has been developed in this country is a misnomer. It implies that there are indeed costs that are not being covered. In fact, that is not true.

What you want to do in examining the issue of cost shifting is to determine each payer's contribution to the net operating margin of the institution. You will find throughout the country that medicare and Blue Cross are good payers.

Mr. MOORE. That is the first time I have heard that.

I certainly have great respect for your position, but that is the first I have heard that. We have had experts who have studied this to a great extent. They are finding that medicare is not paying a fair cost. It is being shifted to the private payers, many of whom hold Blue Cross policies, I would assume.

In any event, I agree with you that the trend is right, of having negotiated payment between providers and purchasers of services such as HMO's, insurance companies as well as business groups.

Mr. TRESNOWSKI. I think you will agree that when you negotiate a price, there will be those institutions which will feel that the price is not adequate to cover some costs. Some might find that this is cost shifting, but it is not. It is a desire on the part of some providers to incur costs that are beyond what is negotiated.

Mr. MOORE. Under first dollar coverage, which I hope is becoming passé, and where an insurance company will pay whatever the charges are and you have the medicare system saying no, all we are going to pay is x amount of dollars, and it is costing the hospital a few dollars more to handle their patients, then the insurers who are paying charges are picking up the difference.

I call that cost shifting as do certain economists who are looking at this area. In our efforts to ratchet down the cost of medicare, I am sure we are having some effect on institutions to become more efficient, but it also encourages them, if they can, to shift off the costs they can't eliminate onto other payers.

Mr. TRESNOWSKI. That I would agree with. That assumes those are legitimate costs, that those are fair costs.

Mr. MOORE. That may be true. I had a Blue Cross high-option plan. I got out of it because the cost went up significantly and you were

Isn't that cost shifting? To me that is cost shifting. Somebody else won't pay that, so they are shifting that over to somebody who will.

Mr. TRESNOWSKI. Maybe they should not have incurred the cost in the first place.

Mr. MOORE. That is true. As long as they have health insurance that pays it, I don't think the patient cares.

Mr. TRESNOWSKI. Not if you have health insurance negotiating a tough bargain with the provider.

Mr. MOORE. That may be true. I had a Blue Cross option plan. I got out of it because the cost went up significantly and you were paying all my bills. I got into another plan where I would pay something and I hope not to be paying those dollars.

Mr. TRESNOWSKI. That is a subject in another area.

Mr. MOORE. I read your statement completely. The other gentleman indicated his solution for perceived cost shifting would be to fix the price for all payers.

Do you subscribe to that same notion?

Mr. TRESNOWSKI. No, we don't. We don't think there is a single system that has demonstrated its value against a heterogeneity of the delivery system in this country. We think it is important that every community be allowed to negotiate a payment system that is sensitive to those local communities.

We also don't think that a single system for all payers enacted by the Federal Government is the right answer. It would be terribly intrusive into the private carriers's business.

We also think that all payers should not pay the same. Some payers have business practices and underwriting practices that entitle them to a differential. They should be allowed to negotiate that.

Mr. MOORE. I agree with you on that point and that is a major reason for the medicare prospective payment proposal before this committee. I do agree with your concerns. I hope we will address some of these by our amendments.

You indicated you would like to see more flexibility. I would, too.

Do you see any value in a community that has more than one hospital of allowing a hospital to go above the DRG if it has to, if the patient is protected, and if the community has another hospital that offers the DRG rate?

Mr. **Tresnowski**. I would say that I don't think, as we said in our testimony, that there should be balanced billing or surcharging. We think that defeats the fundamental purpose of the contract purchased.

However, as we said in the testimony, sticking to that contract price where you have an arbitrarily set price where the provider has no choice other than to cancel his contract, then I think you offer the opportunity to the provider to do what you said. I think under the circumstances you described, that is probably the best solution.

Mr. **Moore**. Thank you very much.

Chairman **Jacobs**. Mr. Duncan.

Mr. **Duncan**. Thank you, Mr. Chairman. I have no questions.

Chairman **Jacobs**. Let me just ask, have you any way of determining whether the $1 Band Aid is also supplied to medicare patients?

Mr. **Tresnowski**. Is also what?

Chairman **Jacobs**. Supplied to the medicare patient? Is there any way of knowing whether the $1 Band Aid is supplied to the private pay patient?

Mr. **Tresnowski**. Absolutely. The medicare cost report which has been in existence for the last 16 years gives the medicare auditor a considerable amount of information to examine the makeup of those costs.

Chairman **Jacobs**. Is it remotely possible they are overcharging everybody for Band Aids?

Mr. **Tresnowski**. I think there has been in the program since the beginning the notion of a prudent purchaser and auditors have had a responsibility to examine those costs from the standpoint of whether the institution has been a prudent purchaser. There have been guidelines established to test that.

Chairman **Jacobs**. Across the water here at the river the Department of Defense does most of this work on a cost plus basis, most of its procurement. There is considerable evidence that an awful lot of junk is being bought at jewelry prices over there. The only private payers there I guess are the taxpayers generally.

It is a true doctrine that everybody's business is nobody's business and that is when prices tend to rise. It seems to me that is the thing that not all of us are going to be interested in looking at, but those of us who have responsibility to the taxpayers and beneficiaries ought to be looking at that.

Mr. Freudig, on the question of all payer coverage, do you think there would be any point in looking into the possibility of giving Uncle Sam the role of the prudent shopper so that the hospital that charged its private pay patients more than the average which you recommend among all the patients would simply lose its contract with the U.S. Government?

As I said yesterday, the Government would shop at the Hot Shoppes and not at Rive Gauche.

Mr. **Freudig**. Are you asking me if the Government would be——

Chairman **Jacobs**. Let us say the hospital charges its private pay patients more than somebody determines is a reasonable price, perhaps the hospital association itself as was the case a few years ago, determining a rate of inflation, and that hospital charges more for its private pay patients, but toddies up to the requirements of the medicare program. The medicare program simply won't do business with that hospital if it exceeds those guidelines.

Does that have any efficacy?

Mr. **Freudig.** I think it would because we have hospitals already that are facing crises where they have a heavier load of patients with the medicare population and as a result of that they are running into serious difficulty.

If the hospital with a lot of private patients does not have to go through that, they can survive. I think we really should look at it down the middle and let us get everyone paying equally. Let the Government pay what it can afford to pay and let everyone else follow suit with that.

Once we are all paying the same charges to the hospital, then we have a fairness arrangement and we can go ahead and begin to solve this problem. I don't see it done any other way.

Chairman **Jacobs.** Have you any opinion on that, Mr. Tresnowski?

Mr. **Tresnowski.** I think I would stay with the point I made before that I think that a contract payer negotiating a price ought to have the authority to audit what he is paying for and compare that against what is being charged other payers.

Chairman **Jacobs.** We are grateful to you for your testimony.

The next panel is Washington Business Group on Health, our friend, Mr. Goldbeck, who can say an awful lot in a short period of time, and Continental Association of Resolute Employers, represented by Kevin P. Rowland.

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

Mr. **Goldbeck.** Thank you very much. I am Willis Goldbeck, president of the Washington Business Group on Health.

I think it is important to say at the outset every cost trend that led the Government to take the steps that are being proposed now, trends that were analyzed in the 1981 and 1982 data, will be worse in 1983. The problem is certainly being very conservatively estimated as we sit here.

Our group comes to this hearing to support the prospective payment system using DRG's and, as the principal large-scale cost shiftees, that is a significant step for us to take. We want you to understand at the outset that there is an awful lot of the cost situation that is not a question of cost shifting, but simply inappropriate pricing and treatment location.

Clearly, a $1 aspirin is not an issue of cost shifting. It is simply gipping an uninformed consumer. It is important to understand that this system does not suggest that it will solve all the health care cost problems. Therefore, it must not be assessed as to whether or not it is a perfect, complete or total system.

There are several points we would like to make at this stage.

The system should have a utilization review component.

It should include preadmission programs to complement the concurrent review and retrospective analysis.

It should not be conducted by fiscal intermediaries.

The Congress should move ahead to fund the PRO program established last year.

States should be allowed flexibility.

We need to have the opportunity for the kind of cost variations and program variations that Congressman Gephardt discussed and if we had not had that opportunity in the past, the DRG system would never have been developed.

We should accelerate the effective date of a uniform hospital billing plan—UB-82—so that it begins simultaneously with the starting date of the prospective payment system.

We oppose any extra patient billing by any provider in the medicare system.

The Congress should establish a timetable of targets for the DRG development for long-term care, psychiatric care, pediatric care, those elements currently left out. That should not be left to research agenda coming out of disparate sources, but you should establish a timetable.

Capital should be included in the per-case price as should physician fees. If that is not possible because of data base now, place it into law now with the implementation schedule later when the data is settled.

Education costs should remain outside the system.

We oppose continued borrowing from the health insurance trust fund with short term pay off for the pension fund.

We oppose shifting the proposal to a hospital by hospital cost basis and prefer to maintain it on an area wide basis.

You must recognize that the use of national norms is a built in hindrance to any progressive system because the national norms contain within them all of the problems that we are trying to correct. The national norms are terrible on every single health care cost and utilization factor because they contain all of the problems of the system.

So, what we are trying to do is develop a process that will, in your words, Mr. Moore, ratchet down the norms. The costs will subsequently follow utilization reductions.

If the system is going to provide a return on the equity for the proprietary institutions, it must provide a commensurate resource development factor for voluntary hospitals.

There is the problem many have raised of the potential of this pricing method exacerbating a two-class system of care. We have a two-class system today. The DRG system will neither cause nor solve the two-class system of care in the United States.

However, hospital and physician specific comparative information on price and utilization will be the available weapon to give those who would like to see a reduction of the two-class system.

We would like to see a full disclosure requirement so that all payers—that includes employers, unions, individual patients, all levels of Government—would have immediate access to price and utilization specific information from all hospitals and physicians, specific by name.

The objective has to be to marry quality clinical information with billing information.

The final discharge diagnosis must be on the bill, not a preliminary diagnosis.

Let me close by saying this is a step in the right direction. It is probably also the last chance for maintaining a pluralistic system and have employers not cross the line to support a total governmental program.

Thank you.

[The prepared statement follows:]

Statement of Willis B. Goldbeck, President, Washington Business Group on Health

HIGHLIGHTS OF TESTIMONY ON PROSPECTIVE PRICING

1. We support a prospective pricing system for Medicare, using DRGs as the method of connecting utilization and claims payment information.

2. The prospective pricing system needs preadmission certification and a concurrent utilization review component. For this reason, we urge the Congress to provide funds for the Peer Review Organization program it established in 1982. Further, we do not support the reliance upon Medicare fiscal intermediaries for the review process.

3. We urge Congress to accelerate the effective date of the mandatory use of the uniform hospital billing form UB-82. There is no reason to wait until 1987. Implementation should be simultaneous with the start of the prospective pricing system.

4. Full public disclosure of all DRG information, by hospital and physician name, is an essential element of the system under consideration. Any patient, insurance carrier, private purchaser (employers, unions and other groups), or level of government should have complete access to this data. Hospital and physician records of all private patient's utilization and price information whether or not by DRG must also be made public.

5. States should be allowed the opportunity for innovative reimbursement and utilization management systems, as long as their cost would not exceed that which they would have experienced under the new DRG-based prospective pricing system.

6. As privatye purchasers, we are very aware that a Medicare-only system runs the risk of cost-shifting. We expect that the only reason hospital representatives are supporting this proposal is because it is less severe than either the cap under TEFRA or some of the state all-payer systems. We will be watching closely. I believe it is safe to say that any signs of massive cost shifting in lieu of system reform, new efficiency, and effective price competition will cause employers to cross the final lines to acceptance of government controls that are national in scope.

STATEMENT

My name is Willis B. Goldbeck, President of the Washington Business group on Health. We appear before you today with concern about the future of our Nation's medical care delivery system. The companies which belong to our Group do so because they, as very large employees, have awakened to the need to become active purchasers of medical care services, no longer remaining passive payers of insurance.

Changing from the current "cost-plus" system of paying for Meicare to a perspective pricing system is long overdue and laudable. As the nations' largest single purchaser, Medicare can, with this new system, set the standard against which the cost management efforts of all other purchasers may be measured. In fact, the proposed system goes way beyond any of the historical tinkering that previous Administrations and Congress have promoted. More than just a cost saving regulation, the proposed system represents a philosophical shift: for the first time the purchaser will have utilization and cost management tools and the provider will have the economic incentive to perform in a cost-efficient style. To move from payer to manager is a progression that we view as entirely consistent with steps being taken by the leaders in the private business sector. Just consider these changes, all of which have taken place within the past five years:

(1) From serving on planning boards to starting planning systems.

(2) From questioning the value of utilization review to contracting with PSRO's to forming multiple employer reviews systems.

(3) From refusing to endorse state rate setting to starting just with a program in Massachusetts. In 1983, employers will be pressing for similar pricing systems in Illinois and Pennsylvania, to name just two others.

(4) From little awareness of the role of the FTC to a defense fo the FTC against the efforts of organized medicine to obtain a broad exemption. Employers have learned at least one lesson these past few years: Medicine is clearly a busines!

(5) From reliance upon the concept of indemnity insurance to an almost total revision of that concept in favor of varied capitation, cafeteria, multiple choice, high-low option, preferred provider, and in-house care delivery programs.

(6) From curiosity about prevention to general acceptance of wellness and employes assistance programs as the fastest growing employee health benefit.

(7) From well-intended but naive reliance upon singular cost control approaches to recognition of the need for cost management strategies that integrate utilization, reimbursement, and capacity-controlling efforts.

(8) From single-company efforts to the coalition movement which can now be found in nearly 100 communities and has the active participation of over 1000 employers.

(9) From acquiescence to providers to outright demands for accountability. This transition is manifested by the new determination to obtain utilization and cost/charge data that will enable the employer, unions, and individuals to compare physicians and hospitals by name, and thus guide provider preferences.

Taken together, these changes represent an evolution from the giving of a benefit to the management of an asset.

It is our position that the proposed prospective pricing plan for Medicare should be supported. We come to this conclusion fully aware that the proposed system addresses only some aspects of the total medical cost problem, that an increase in cost shifting may result, and that there will inevitably be further changes needed as we learn from the new system's implementation.

Changing to the prospective approach poses a major challenge to all parties in the private sector. If hospitals fail to enact the cost efficiencies that are available to them and simply try to shift any new expenses to private payers, employers will be left with no choice other than joining in the call for expanded government controls on the total system. If physicians do not signficiantly change practice patterns, hospitals will be left with no choice other than imposing new practice standards with decreasing flexibility. If employers, unions and employees do not work together for benefit design reform to lessen medically unnecessary demand, not only will costs continue to rise but also the quality and appropriateness of costs will continue to decrease.

We do not desire a totally governmental delivery system. We believe that diversity of systems is necessary for the innovation that made medicine in the USA the world's best. We believe that the Medicare prospective pricing system can be a major stimulus for getting costs under control, building a long overdue utilization and pricing data base, and achieving balance between regulation and price competition.

Criteria for success

It is our position that there are several elements needed to make the prospective system a success:

(1) Utilization Review must be made part of the system. Fiscal intermediaries should not be the review group. The review should be concurrent (providing DRG verification) and will be supplemented by the Administration's plan for a sample retrospective review. Every effort should be made to develop preadmission certification programs to complement the concurrent review and retrospective analysis. We urge Congress to fund the PRO program which became law last year. This program, developed under the leadership of Senator Durenberger, is being eliminated by the Administration by the simple procedure of refusing to put it in the budget. This is in direct violation of the stated intent of Congress, and of the desire of private purchasers. Further, it will weaken their own prospective pricing program which is generally modeled on the New Jersey program in which utilization review has proven to be an essential component.

(2) States should be allowed to apply for waivers if they develop reimbursement and utilization control systems that promise to be at least as cost effective as the new Medicare system itself. We must remember, if it were not for just such waivers in the past, the DRG system experiments would never have been implemented. At the state level, all payer systems, competitive bidding systems, and hybrids of those approaches should be allowed to flourish, even to fail. We should not be afraid of

failure in the search for improvements. After all, it is hard to imagine a bigger failure than perpetuation of the status quo.

(3) A final basic criteria is a full disclosure requirement for all providers, regardless of payer. Medicare utilization and pricing data must be available to all. Comparable utilization data for all other payers, physician and hospital specific, must be public. UB-82, which should be required simultaneously with the effective date of the prospective pricing systems will be an important asset in the movement of the private sector toward per-case reimbursement. The providers must realize that any further unwillingness to accept such a full disclosure requirement will result in private payers pressing for a governmentally mandated all-payer rate setting system.

Issues and concerns

Change of the magnitude represented by the prospective pricing proposal carries with it considerable risk and raises many issues which, while not impenetrable barriers to implementation, do deserve consideration. In the list which follows, we present our concerns, cautions, and reactions in the hope that Congress and the Administration will find these useful as the prospective pricing plan's details are developed.

(1) We do not believe hospitals or physicians should be allowed to bill Medicare patients for any charges, other than legislated cost sharing, above those paid by Medicare. Medicare patients are already responsible for more of their own costs than most who are far more financially secure. Allowing extra charges would subvert the basic principles of the prospective pricing concept.

(2) Congress should establish the timetable by which DHHS must develop DRGs for outpatient, psychiatric, and long term care. Physician fees and the cost of capital should also be included as soon as possible. Medical education and research should remain separately funded programs.

(3) It has been suggested that major employers can unilaterally control cost escalation in the private sector. This is not true. A primary reason for the full disclosure requirement identified above is the simple fact that even our biggest companies are, in most locations, small employers. Although they tend to grab the headlines, there are actually few cases of a company town where one, or even a few, employers dominate the hospitals. Congress needs to know this and establish the information systems that will enable purchasers of all sizes to act prudently based on sound comparative information. Employer involvement should be dependent upon knowledge, not economic muscle which itself is no guarantee of action that will be beneficial to the community as well as the company.

(4) Concern has been expressed for the quality of clinical data now on claims forms. In our view, the poor quality will diminish in direct proportion to the use of that data for reimbursement purposes. The DRG system will force hospitals to invest in better records systems and personnel. In establishing the prospective pricing system, we should not be detoured by the failure of the medical community to marry billing information with final diagnostic information. Hospitals should not seek special government financial assistance for data processing systems. Doing so would make no more sense than having the SEC pay banks to meet their reporting requirements.

(5) A data issue of greater concern is raised by the use of historical utilization and pricing norms to establish the DRG votes. Virtually all national norms are much higher than need be; this problem is even greater in many local areas. Today's norms are the product of the economic incentives and traditional practice patterns we all agree must be changed. Compounding the problem is the effort during the past several months, that many hospitals have undertaken to get this cost base as high as possible. While it is understandable that this activity would take place, the activity itself is both unethical and inflationary. Perhaps the data rates should be set on a 1981 base with a national inflation factor to avoid this hospital-by-hospital base factor loading. In addition, the problem of using old norms calls for a review and downward revision of DRG rates after the program has been in place for two or three years. This review should be separate from the other, annual rate setting procedures designed to keep the system current.

(6) One of the difficulties in monitoring the impact of the DRG system is the absence of outcomes validated utilization standards. In order to make progress in this lengthy and complex task, we support the concept, espoused by Senator Baucus for a Physician Advisory Commission on Clinical Practice.

(7) Many have expressed concern that the prospective pricing proposal may result in a two-class medical care delivery system. There is no question that underservice could result and some hospitals might refuse to care for the poor and elderly. What Congress and the public must face is the reality that today we have the worst form

of two-class system. We promise a simple-class system, but dash those hopes against barriers of unequal payment, explicit rationing, implicit rationing as exemplified by the AHA guidelines on how hospitals can keep out the poor, unmet Hill-Burton obligations, dumping of patients on public general hospitals . . . the list is endless. In the currrent system, "second class" care is hard to identify, much less correct. The problem is not the quality of care practiced by the physicians, rather it is the entry system and the methods of resource allocations for the care of patients for whom reimbursement is less than the amount desired by the hospital.

DRGs and prospective pricing will neither cause nor cease the two-class problem. However, having the utilization and pricing comparative information that results from a DRG system can be a valuable tool in the hands of those—and I would include our Group in this number—who would work for the end of the hypocrisy of our current system.

Conclusion

As private sector purchasers, we are taking a risk by supporting a Medicare-only system. We understand this but believe that too few of the details of prospective pricing are known or tested to move directly to a fully national system. We would also like to believe that, while learning from the Medicare experience, we will see a convergence of cost management forces from employers, consumers, and innovative state systems. The management tool and information base of DRG prospective pricing represents a big step in the right direction. It may also represent the final chance for a pluralistic delivery system, essentially private, that honors our public commitment to quality care for all.

Chairman JACOBS. Thank you, sir.

Mr. Rowland.

STATEMENT OF KEVIN P. ROWLAND, CONTINENTAL ASSOCIATION OF RESOLUTE EMPLOYERS

Mr. ROWLAND. Mr. Chairman, and members of the committee. My name is Kevin Rowland. I represent C.A.R.E., the Continental Association of Resolute Employers, a national small business service association which serves the needs of our 70,000 members.

My organization's concern regarding the proposed medicare prospective payment system stems from the inflationary situation now unique to health care and affecting our Nation's health care delivery system.

In 1982 health care costs rose 12.6 percent. This is more than three times the overall inflation rate of 3.9 percent. Our membership, mostly small business employers and employees are finding double digit inflationary increases in their health insurance premiums to be overwhelming.

According to the U.S. Chamber of Commerce's employee benefits survey, 60 percent of the inflationary costs are being carried by small business. In light of the economic problems facing small business and the rising costs of health coverage, C.A.R.E. finds that many small business operators are canceling their health insurance.

The impact of this situation is dramatized in a recent event. A C.A.R.E. member was forced to cancel his company's health coverage due to his economic problems and a steep premium increase for 1982. This man was killed this past week in an auto accident. His wife suffered injuries, and advises C.A.R.E. that she is now faced with an overwhelming $30,000 in hospital bills.

The majority of the premium increase is due to cost shifting. Unless cost shifting is stopped, we will see an increase in such situations.

It is estimated that $6 billion of the health care premium increase is due to the cost shifting created by the currently inadequate medicare reimbursement system. Because the medicare payment system does not reimburse hospitals for the total expenses incurred, these financial losses are charged to the private payer in the form of higher health care costs which are reflected in correspondingly higher premiums for health insurance.

With a revised Medicare reimbursement system, using HHS's prospective payment system as a base, this Nation's health care delivery system could become more equitable and therefore affordable for small business.

As the prospective payment system is developed, the following principles should be applied to insure the system will be equitable to all payers which will particularly be beneficial to 37 million Americans employed by small business. These principles include:

One, consistent financial incentives for all participants to control the growth of health care spending over the long term.

Two, the needs of all participants in health care—users, providers and the Government—must be balanced.

Three, the financial interests for all parties involved must be balanced.

Four, users' choice of and access to quality health care must be created through incentives and adequate payment to the providers.

We recommend that the continuation of waivers for medicare alternative payment systems such as found in Maryland and New Jersey, should be continued and encouraged. Only through innovation can the entire medicare program evolve and adapt to the changing conditions in the health care marketplace.

The adopted medicare payment system should also provide and expand the contracting for services on a capitation basis, a pre-paid health care system. By using this cost saving alternative, the Federal Government would take advantage of the successful health maintenance organizations which today provide quality, low-cost care to millions.

This procedure should substantially reduce the cost shift problem that is now impacting so heavily on those who rely on private insurance coverage and they are primarily employed by small business.

In addition, income testing would provide a sliding schedule for copayments and deductibles based on the beneficiary's income. This concept is similar to the proposed social security benefit tax which is included in the social security reform legislation currently being considered by Congress.

Under an income test future billions could be cut from Medicare payments. The effect would be another reduction in cost shifting.

Mr. Chairman, C.A.R.E. recommends that a prospective payments system be enacted. The current system will only allow the continuance of cost shifting and the impact which small business employers and employees can no longer suffer.

It is through adoption of a prospective payment system Congress will be taking the first step toward healing our health care delivery system. Congress should continue to address health policy issues which spur marketplace competition and restrain the overutilization of our health care system.

The Continental Association of Resolute Employers is prepared to work with Congress and the administration to develop an equitable and acceptable health care delivery system.

Thank you.

Chairman JACOBS. Thank you.

Mr. Moore.

Mr. MOORE. Both you gentlemen heard the question I have asked several times trying to make the DRG system more competitive by urging hospitals to go below the DRG and letting the patient who chooses the hospital to pay less deductible.

What do you think of an idea like that?

Mr. GOLDBECK. You will find relatively few hospitals which will volunteer to charge less than they have to, particularly since the DRG system as it is designed in this proposal gives the hospitals an incentive to stay under the DRG level because they can keep some of those revenues.

I would prefer not to allow charging individual patients any more than the legislated cost-sharing requirement. This should not be a matter of a debate between the individual hospitals, individual physicians, and individual patients on a per procedure basis that would vary within given communities.

We have to resolve this on a national basis and decide how much we want medicare patients to pay.

Mr. MOORE. If you have hospital posting rates below the DRG level, they attract patients, particularly in the areas of expertise where the hospital is making money, would that not help?

Mr. GOLDBECK. That helps, but there is no reason to charge the individual patients more if they go elsewhere.

Mr. MOORE. The patient has a choice. It may be that the patient wants to go to a certain hospital even though it is less efficient.

Mr. GOLDBECK. Unfortunately, the issue is not just the posting of available pricing information. There is precious little information available on validated outcome measures so that an individual patient would know, for instance, that on open heart surgery, if the price posted in hospital A is a third less than the price posted in hospital B, in fact, the quality is only 20 percent as high because they only do 15 cases a year and they are trying to get more business. We know, due to various kinds of scientific research, they ought to be doing 200 cases a year to get high quality accepted outcomes.

In heart surgery we know about what the standards are because the work has been done. That is one of the few kinds of medical procedures on which there is that quality related, comparative information available to the consumer.

Price should not be the only driving factor in guiding a medicare patient.

Mr. MOORE. In moving to a competitive system, isn't price part of it?

Mr. GOLDBECK. We do not advocate, even though we are supportive of moving toward a more competitive system, having the price being the sole determinant because there is risk of reduced quality of care for individuals who have no way to make a choice.

Mr. MOORE. We are presupposing that the consumer does not have good sense. That is a mistake. Certainly the consumer, the medicare patient, will talk to his physician about where he must go to have this operation.

I am presupposing you are trying to get hospital costs down. So are we. Maybe we ought to try to make the DRG system more competitive.

Do you worry about cost shifting for the companies you represent?

Mr. GOLDBECK. It is not just a matter of relying on the medicare patient negotiating with this physician over which institution in which to receive care. We have freedom of choice in the technical sense, but we don't have very much meaningful choice. The average medicare patients, when they are faced with an operation, are not told, "There are the five institutions. You don't have to have it with me. I only have privileges in two of those. Here are the others you can go to to get that care. This is the quality validated outcome measures in those institutions. Now make an informed choice."

You are not given an array of Georgetown or George Washington. You are told, "This is where I work. This is what I need. This is where I can get you in."

Mr. MOORE. There is no incentive for the former case?

Mr. GOLDBECK. On a great many procedures we don't have the information even if the incentive is there. We have not done the work. That is one of the major areas of health services research that is needed to get quality validated outcome measures for various kinds of health procedures.

Mr. MOORE. When a patient makes a choice, he is going to be concerned about the money. If there is no difference in the money, he is not concerned where he is going.

Mr. GOLDBECK. Moving toward an incentive where the DRG allows hospitals to keep a responsible share of the difference between the DRG payment and more efficient method of delivery is a very good first step.

Let us get that system in place. If we begin to have the kind of information that lets people make qualitative judgment as well as pricing judgment, then we will be in a position to move toward the added incentive.

Mr. MOORE. Why are we worried about the patient? Let him make the decision.

Mr. GOLDBECK. Since our employers provide medical benefits for 50 million people in the United States, we have a responsibility to be worried about the quality of care they get. We know, for example, based on research done in this past year, 55 percent of the hospitals in the United States that do open heart surgery and 40 percent of those that do cardiac catheterization don't do enough volume to achieve proficiency, yet the patient is not being told, don't go there.

I think we have a responsibility to get the new incentive based system phased in in a responsible fashion.

Mr. ROWLAND. I believe the concept of assigment and nonassignment can be implemented properly as long as we are assured there is availability of care in areas where there is a shortage of hospitals.

I believe a preferred provider system like that could work out to the benefit of all.

Mr. **Moore**. Thank you, Mr. Chairman.

Chairman **Jacobs**. Mr. Shannon.

Mr. **Shannon**. Thank you very much, Mr. Chairman.

Mr. Goldbeck, you said that you thought it was wise for the hospital to be able to keep a share between the DRG and the cost of treatment. I think under this proposal the administration is sending us they will be able to keep the whole difference, not just the share.

Mr. **Goldbeck**. I stand corrected.

Mr. **Shannon**. What do you think about that?

Mr. **Goldbeck**. I think it is fine if they get to keep the whole difference. The exact percentage is not the issue per se.

I would agree with the tenor of Congressman Moore's remark that we are trying to instill more price incentives where they do not conflict with quality incentive.

Mr. **Shannon**. So you are not locked into it? You think that on the whole it is justified?

Mr. **Goldbeck**. I do. We don't have the kind of experience base that we can say that it would make more sense to do 48 percent than 40 percent or 62 percent.

We need to try it and we need to see how the variations do work out. It is very easy for you or for the administration administratively to change that percentage at any time in the future. That is not a serious issue.

Mr. **Shannon**. Very easy for us to do it? I am glad to hear that, Mr. Chairman.

Mr. **Goldbeck**. The system is in place.

Chairman **Jacobs**. Mr. Duncan.

Mr. **Duncan**. Thank you, Mr. Chairman.

Mr. Goldbeck, you mentioned that if a return on net equity is paid for profit hospitals, that it also should be paid for nonprofit hospitals. Should a return on net equity be allowed for high cost hospitals that exceed the established DRG rate?

Mr. **Goldbeck**. I think we need to move to a system where we provide disincentives for institutions that are high cost as a result of unnecessarily high style patterns of practice. I don't purport to have a formula at the tip of my tongue to suggest to you on that.

The point I was trying to make is that today you have the voluntary hospitals struggling as a matter of necessity to figure out ways to accumulate reserves and excess revenues that don't show up on cost reporting forms because then it would be taken away.

We all know that any institution, if we do wish to have it maintained, if our objective is not to close it down, has to maintain the capital plant and do those other things that relate to the availability of capital.

If only one segment of the hospital business in the United States has access to capital, they obviously are at a major advantage. That advantage would not relate to quality of care, needed care, location or any other issues about which you gentlemen have great concern.

We need to find some methodology for preserving that capital factor for the voluntary hospitals, or remove it for all categories of hospitals.

Mr. **Duncan**. Thank you very much.

Thank you, Mr. Chairman.

Chairman JACOBS. Thank you both for your testimony.

The next panel consists of the American Nurses' Association, Inc., Barbara Curtis, and American Medical Record Association, Sally Simons.

You both know the rules of the "State Athletic Association".

STATEMENT OF BARBARA CURTIS, R.N., AMERICAN NURSES' ASSOCIATION

Ms. CURTIS. I am Barbara Thoman Curtis, a registered nurse from the State of Illinois, consultant to the Illinois Nurses' Association on medicaid/medicare. This is a result of expertise gained from firsthand experience. I am medically disabled and am a medicare subscriber.

I am testifying on behalf of the American Nurses' Association.

Mr. Chairman, I would like to highlight some of our concerns about the administration's proposal for prospective payment for medicare and make several recommendations regarding this legislation. I ask that our full statement be included in the record.

We agree with the premise underlying the administration's plan that under the current retrospective cost reimbursement system, hospitals have no incentive to deliver services in a cost efficient manner. We believe that prospective payment is a promising alternative.

However, there are other important concerns which must be addressed in designing a major revision in the medicare program if cost efficiency is to be encouraged while quality maintained.

Both a prospective payment system, in general, and the DRG mechanism, specifically, have many implications for the quality and cost efficiency of health care, not only in the medicare program, but for the entire national health delivery system.

We seem to constantly create payment mechanisms and then attempt to mold our health care delivery system to fit into them. It would seem desirable to create an efficient health care system, then determine the reimbursement mechanism.

A major shortcoming of the administration's proposal for prospective payment is that it applies only to medicare. We believe that it is absolutely essential that any cost containment mechanism apply to all payers.

Without uniformity among payers, the system is open to tremendous gamesmanship to shift costs, rather than to encourage improved management efficiency.

Second, it is also crucial that a cost containment proposal apply to all providers, not just hospitals. Any incentives for cost efficiency must apply also to physicians who make the majority of health care decisions.

The administration's proposal does not provide safeguards against skimming, dumping and manipulation of patient mix. Clearly, this will lead to a tremendous burden on the public hospitals, which then assume the responsibility for treating the most ill, and, therefore, most costly patients.

The administration's proposal has failed to provide for professional standards review, and has failed to develop an enforcement mechanism that provides the best incentive to providers.

The DRG mechanism, itself, has many limitations. By averaging the cost of care, the DRG system would pay all providers the same whether certain services were provided, whether adequate staffing levels were maintained and for care which may be substandard.

The DRG mechanism does not adequately reflect the intensity and variety of necessary support and assistance required by a particular patient and family. The need for support and assistance from nursing personnel, is an individual determination influenced by such things as the patient's level of knowledge about the diagnosis and the impact on his/her life, the capacity of the patient and family to participate, and the cultural background.

If DRG determination bears any relationship to social security disability determination, I am here to say, from personal experience, it doesn't work.

While hospitalized 3 years and in intensive care, I was notified that each of my several diagnoses was "not sufficient to be indicative of a disability."

Hypertension, diabetes, chronic kidney disease, neurogenic bladder, congestive heart failure, peripheral neuropathy, each DX was considered singularly. The interactions could not be dealt with in the bureaucracy until 1 year and 3 levels of appeal. Later, the decision was reversed by an administrative law judge.

The DRG mechanism is insensitive to the amount of time that may be needed to determine the proper treatment approach for an individual when physiological imbalance is complex, severe and unstable.

To relegate these individuals to the "outlier" group may become more the norm than the exception in the future years as hospital stays are reduced and more treatments are performed outside the hospital.

Another drawback we see is that DRG's, because of the use of a number of procedures in calculating payments, favors surgical treatment over nonsurgical. Such a basis in payment will do nothing to curtail the number of surgical procedures performed and will do even less to encourage research for nonsurgical approaches.

Mr. Chairman, we call your attention to eight recommendations in our written statement. We believe more study and evaluation must be undertaken, not only of DRG's, but other classification systems. More study is needed on how they will be implemented and interact with State programs.

Medicare coverage should be broadened to allow more comprehensive community based and in home health services. Earlier discharge from hospitals is only a desirable result if sufficient out patient clinics and community and/or home care exist.

A recently introduced bill, S. 410, addresses this goal and provides for community based nursing services.

We thank you for this opportunity to present our views and will be happy to work with the committee in its further deliberations on this matter.

[The prepared statement follow:]

STATEMENT OF BARBARA CURTIS, R.N., THE AMERICAN NURSES' ASSOCIATION

The American Nurses' Association is the professional association representing the nation's registered nurses. We are pleased to have this opportunity to present our views on the Administration's prospective payment proposal for Medicare.

The American Nurses' Association is and has been gravely concerned about the rapid escalation in health care costs which threaten not only Medicare, but also the quality and access to care for the entire population. It is clear that policy makers must act to slow this rapid escalation in order to improve both the financial outlook of the Medicare program and the quality of and access to the nation's health care delivery system.

We would like to comment on the Administration's proposal for a hosptial prospective payment mechanism for Medicare, based on the Diagnostic Related Groups (DRGs). Under this system, Medicare would establish the hospital payment rates in advance, rather than, as under the current system, paying hospitals for whatever costs they incur in treating patients. The established rates would be based on a patient's diagnosis, using one of 467 DRGs to classify a patient's illness or treatment. All hospitals would be paid the same rate for treating a given diagnosis, although rates would be adjusted for variations in local labor costs. Hospital capital costs would be treated separately and separate provisions would be made for hospitals where costs are higher due to medical education.

We agree with the premise underlying the Administration's proposal that under the current retrospective cost reimbursement system, hospitals have no incentive to deliver services in a cost-efficient manner. Because hospitals are reimbursed for the costs they incur, this method actually rewards excessive costs and inefficiency. We agree, therefore, that in the efforts to control health care costs and improve the Medicare program, it is important to focus on incentives and disincentives for providers.

However, there are many other important concerns which must be addressed in designing such a major revision in the Medicare program if cost-efficiency is to be encouraged while quality is maintained. We would like to address what we believe are essential components of any cost-containment effort, and thus the factors that must be considered in establishing a prospective payment mechanism. Within this framework, we believe that the Administration's proposals fail to address adequately, many important factors.

It is clear that policy makers must act quickly to resolve both the benefits and financing dilemma facing the Medicare program. Although neither the issues nor options are simple, we feel that there are three essential principles to which the solutions must adhere. Within these principles, there are proposed solutions which policy can take which will maintain the integrity of the Medicare program.

First, the Medicare program must be preserved as a system which provides the elderly and disabled with appropriate, high quality and cost effective protection against the expenses associated with poor health, rather than a system which increases the burden of these vulnerable populations. The health of our aged and disabled citizens is vital to the overall well-being of our nation. We cannot afford, nor is it desirable, to erode the quality of health care we provide these people. In fact, it is crucial that solutions concentrate on exploring options to expand and improve the benefits and coverage of the Medicare program.

Second, the changes must ensure the future financial integrity of the Medicare program, as an insurance program whose major beneficiaries are patient populations. Changes in the financing of the Medicare program must address the fact that the health care delivery system which has been fostered under the Medicare program, is provider-dominated.

Third, although changes to the Medicare program should not be used to accomplish all of the nation's health cost-containment goals, any changes made must be within the context of the entire national health delivery system. Such a system must include all payors, all providers and all vendors. Otherwise, changes will merely shift costs from the Medicare program to other sources, not affecting the overwhelming problem of escalating national health expenditures, and presenting a real danger of creating a three-tiered system of health care delivery. Solutions must take into account all of the major sources of cost escalation, including pharmaceutical and medical supply industries, as well as the actual health care providers.

THE ADMINISTRATION PROPOSAL

It is against these standards that the Administration's proposals or any health care cost-containment system should be evaluated. Both a prospective payment system, in general, and the DRG mechanism, specifically, have many implications for the quality and cost efficiency of health care, not only in the Medicare program but for the entire national health delivery system. The Administration's proposals, however, fail to take into account the many crucial factors which affect both the cost-effectiveness and quality of health care. Furthermore, we are concerned that the system which will be implemented in a major, national program, is patterned after a state experiment for which the experience is limited. Moreover, the Administratin's proposal will come on top of already major changes recently implemented in the Medicare program, the effects of which are not yet known.

A major shortcoming of the Administration's proposal for prospective payment is that it applies only to Medicare. We believe that it is absolutely essential that any cost-containment mechanism apply to all payors. Without unformity among payors, the system is open to a tremendous amount of gamesmanship to shift costs, rather than encouraging improved management efficiency. A system which applies only to Medicare provides greater incentives for shifting costs than for controlling costs. Moreover, the lack of uniformity, coupled with cutbacks in Medicaid, will result in the development of three classes of health care: private, public and Medicare.

It is also crucial that a prospective payment system apply to all providers, not just hospitals. Any incentives for cost-efficiency must apply also to physicians who make, by far, the majority of health care decisions, and, therefore, are crucial to the success of any cost-containment efforts. It is unrealistic, and largely beyond the control of hospitals, to expect physicians to respond differently to different types of incentives.

The Administration's proposal does not provide safeguards against skimming, dumping and manipulation of patient mix. Clearly, this will lead to a tremendous burden on the public hospitals, particularly, which will end up assuming the responsibility for treating the most ill, and, therefore, most costly patients.

The Administration's proposal has failed to provide for professional standards review, and also failed to develop an enforcement mechanism to ensure a certain level of quality care. When cost containment requirements are placed on the health care industry, the need for quality assurance, peer review, appropriate use and distribution of resources increases. It is of great concern to ANA that those mechanisms provided for by Professional Standards Reveiw organizations and Health Planning Systems have been significantly weakened by recent legislation. Although the PSROs and HSAa were far from perfect, both programs contributed to the maintenance of peer review systems and the prevention of over proliferation of technologies and overbedding and overbuilding.

Without strong federal deterrents, costs can be expected to continue to spiral with subsequent diminution of patient access to quality services. We maintain, that regardless of the method chosen to encourage cost-efficiency, an effective enforcement mechanism provides the best incentive to providers.

The DRG mechanism, itself, has many limitations. It is not, as seems to be assumed, a penacea and when used as the sole categorization for determining payment, ignores many important variables.

The DRG proposal provides no way to measure qualitative differences in care and, therefore, may reward providers for substandard care and may penalize those who provide high quality care. The Administration's proposal, by averaging the cost of care, would pay all providers the same whether certain services were provided, whether adequate staffing levels are maintained, and for care which may be substandard. The DRG proposal, by not providing any definition of the product which Medicare is purchasing, is leaving a tremendous amount of discretion to hospitals to determine what Medicare will pay for, subject to enormous variations and regrettably, but most assurdly, abuse.

The DRG mechanism does not adequately reflect the intensity and variety of necessary support and assistance required by a particular patient and family or by the grouping. The need for support and assistance from nursing personnel is an individual determination that is influenced by a variety of factors including the patient's level of knowledge about the diagnosis and the impact on his or her life-style and future capabilities, the capacity of the patient and family to participate in the caregiving process, and the present of disablihg conditions associated with the aging process, prior incidences of disease, debilitation or trauma, and the patient/family's cultural background. Even in some states where measurement of the relative intensity of services have been attempted, the result has been a retrospective determination of the costs of services provided but not of the care and services needed by the patient or the grouping.

Use of the DRG inappropriately assumes that medicine and nursing have established proven mthods of treatment of all medical diagnoses and combinations of diagnoses. The DRG mechanism is insensitive to the amount of time that may be needed to determine the proper treatment approach for an individual when physiological imbalance is complex, severe, and unstable. To relegate these individuals to the "outlier" group is to be blinded to the true cost of care.

The cost-savings in the DRG proposal is based, partially, on the premise that length-of-stay will be reduced. As length of stay in the hospital decreases and as more medical and surgical treatments are performed outside the hospital, the numbers of patients who can be described as having complex, severe, and unstable conditions in the hospital will increase. The "outlier" group may become more the norm than the exception in future years and the prospective payment mechanism must be able to accommodate this. Moreover, when length-of-stay is already relatively short, such as, for example, in the Pacific Northwest, this mechanism may force hospitals to put patients at risk by premature discharge.

The DRG schema assumes that emergency treatment and elective treatment require equal amounts of resource; with respect to the use of nursing services, the patient and family need for support and assistance varies widely with this variable. Additionally, the DRG approach assumes that individuals within any grouping with the same diagnosis present themselves for treatment under the same conditions. Whether the treatment that is required in elective will influence the condition of the patient but other factors, such as the patient's nutritional status and hydration level, are important determiners to response to treatment as well as to the use of resources.

Because of the use of the number of procedures in calculating payments, the DRG mechanism favors surgical treatment over non-surgical treatment of a condition. Such a bias in payment will do nothing to curtail the number of surgical procedures performed and will do less to encourage research and continued clinical exploration for non-surgical solutions to health problems. We do not wish to suggest that all surgery is unnecessary but rather we wish to stress that surgical intervention is but one of a variety of modes if treatment for many conditions. To encourage surgical interventions through a payment mechanism is unwise.

In summary, the DRG mechanism does little to recognize the reality of care and services provided by professional nurses to hospitalized patients or to recognize the varying needs and conditions of the patients. Although the DRG mechanism may appear as a manageable, logical approach for payment, the problems cited earlier will diminish any savings or cost control anticipated. We urge your consideration of other classification schema that include the patient's and family's need for support and assistance as well as the overall condition of the patient for determining the payment to hospitals for care and services rendered; such classifications do exist.

CONCLUSIONS

In light of these serious concerns we urge the committee to consider the following recommendations in the development of legislation encompassing a prospective payment mechanism.

1. An evaluation of the effect of reimbursement changes enacted under TEFRA should be initiated to determine the impact of those changes on public and voluntary non-profit hospitals, patient care services, utiliztion of services, patient care staffing and, if possible, the qualtiy of care.
2. A rate-setting mechanism should be developed which would extend to all providers, professional as well as institutional.
3. The prospective payment system should include mechanisms which would effectively contain costs for capital equipment and other vendor costs.
4. In states where rate setting programs apply to all payors, the federal medicare prospective payment program should accept the rate established by the state for beneficiaries regardless of classification system used. In addition, the federal government should undertake a study to evaluate the effectiveness of this arrangement.
5. In as much as the DRG mechanism is still in an experimental stage, early legislation should address implementation of DRG's and other classification systems on a trial basis. Consideration should be given to the severity of illness index such as the one under study at Johns Hopkins University and the relative intensity measures (RIMs) which are being evaluated in New Jersery. Other mechanisms for prospective payment such as per diem, per capita rates should also be evaluated. There is no strong evidence to support the DRG methodology as being superior to other classification mechanisms.
6. In recognition of the fact that the availability of nursing services in a hospital is the major reason why patients are admitted for care, any future system for medicare payment must include the recognition of the need for and the cost of the services of professional nurses through a classification and accounting system. The

present system hides nursing services udner the general rubric of routine operating costs and thereby places nursing services in a highly vulnerable position and a prime target for the budget cutting ax. This, ultimately adversely affects the qualtiy of patient care.

7. Medicare coverage should be broadened to allow for more comprehensive community based and in home, health services. Earlier discharge from hospitals is only a desirable result if sufficient outpatient clinics and community and/or home care service capacities exist.

In addition any changes made in Medicare to accommodate the increased need for community services should be accompanied by similar cost containment provisions to prevent increased and uncontrolled costs in other areas of the health care delivery system. A recently introduced bill (S410), addresses these important goals and provides for community based nursing services.

8. Finally, it is imperative that an effective enforcement mechanism be implemented to ensure adherence to certain standards for the delivery of health care service and to curb the natural tendency to skim, dump, manipulate patient mix.

We thank you for this opportunity to present our views and will be happy to work with the Committee in its further deliberations on this matter.

Chairman JACOBS. Thank you.

Ms. Simons.

STATEMENT OF SALLY SIMONS, RRA, DIRECTOR OF MEDICAL RECORDS, OVERLOOK HOSPITAL, SUMMIT, N.J., ON BEHALF OF THE AMERICAN MEDICAL RECORD ASSOCIATION

Ms. SIMONS. My name is Sally Simons. I am director of the medical record department at Overlook Hospital, Summit, N.J., one of the original 26 DRG experimental hospitals billing all payers in the State of New Jersey since 1980.

I am here testifying on behalf of the American Medical Record Association, representing 25,000 medical record practitioners across the country. We are glad to have the opportunity to testify today and will sacrifice the opportunity to get the dollar in the interest of a more comprehensive statement.

Chairman JACOBS. That offer still applies.

Ms. SIMONS. We have several points we would like you to consider in developing prospective reimbursement.

The medical record departments have long been a source for clinical data reporting, patient pay epidemiology, and third party payment as well. With the possible implementation of DRG's as a nationwide reimbursement mechanism for medicare patients, data collection and reporting will be the supporting vehicle, not only for billing, but also for management reporting which is the basis for addressing inefficiencies in hospital care, the overall purpose of a prospective reimbursement plan.

We speak to these points, based not only on our experience with the New Jersey experiment which utilized DRG's as reimbursement for all payers, but from our experience and expertise as medical record professionals whose training has long focused on data collection, classification, and reporting.

Utilization of these data for reimbursement will not alter our procedure for qualitative data reporting. We ask you to consider the following points relating to data collection.

Data definition. DRG's are calculated on certain variance, principal diagnosis, significant secondary diagnoses, hospital complications and other conditions which existed at the time of admission and which have impact on length of hospital stay.

In developing any nationwide system, it is imperative all participants understand the rules of the game and that they be clearly defined. Rules or terms for national clinical data reporting have been defined in the UHDDS. Even these materials need to be further clarified and expanded so no potential for misinterpretation or fraudulent use of data can enter into the reporting process.

Some misunderstanding of terms surfaces in Secretary Schweiker's report.

Data collection is the second point we would like you to consider. Consideration must be given to how data are collected for the future. The MEDPAR data base is flawed because of the data collection methodology, a fact which the Secretary attests to on pages 93 and 94.

The data were collected in a narrative form in hospital billing offices based on information collected from the patients at the point of admission to the hospital. It is not an adequate picture of the patient's subsequent hospital course and resource consumption.

Further, the data were classified according to ICD 9 CM classification system without access to either the source document, the medical record, or treating physician.

Additionally, the data fields on the MEDPAR bills were inadequate for total representation of the patient's clinical picture. The Secretary states that the data for establishing rates are inaccurate, but that the inaccuracy is of no consequence as it is to the hospital's advantage.

We feel strongly that a nationwide system which could determine the future health of the hospital-should be based on the best available data. Future data reporting, therefore, should be designed to obtain data from the source document, the medical record, by hospital-based personnel who are trained in ICD 9 CM classification and have access to the treating physician.

Finally, definition of case mix. Because you are considering fast track, I suggest you look more closely at consumer outliers. Secretary Schweiker's report addressed the concept of high outliers. There are a number of other patients in hospitals who really are atypical in terms of their resource consumption.

In the New Jersey experiment we have included all patients who expire in hospitals, those who consume a large number of resources, and low length of stay as outliers. If these are not included, it might encourage unnecessary admissions which might be better done on an outpatient basis.

Finally, clinical outliers, those peculiar DRG's which contain patients whose diagnostic information is so various as not to be homogeneous at all.

Further, we encourage the Congress to look more closely at revisions to the conditions of participation which relate to medical record documents. They are looking to expand the time to complete records to make documentation probably harder to get and less accurate than it is now at this point.

Finally, we would like to offer the assistance of the American Medical Record Association in the development of the prospective payment. The ICD 9 CM DRG's were developed at Yale and refined in the New Jersey experiment with assistance of clinicians and medical record practitioners who helped to clarify the data base.

Thank you.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN MEDICAL RECORD ASSOCIATION, CHICAGO, ILL., PRESENTED BY SALLY SIMONS, RRA

SUMMARY

The American Medical Record Association representing 25,000 medical record professionals nationwide has a continuing concern for the quality of data generated in this country's hospitals. That concern extends to data used for reimbursement, and we offer the following considerations:

Need for clear definitions of data

In developing a prospective payment system to be used nationwide, clear definitions of terms are necessary for uniform reporting and interpretation of data. We recommend adherence to the already established uniform hospital discharge data set.

Need for accurate data base

A national system of reimbursement based on clinical data should have accurate data available. We recommend that future data reporting be designed to obtain data from the medical record by personnel trained in disease classification.

Need for clinically coherent case mix

The New Jersey DRG experiment allows several types of atypical cases to be reimbused for cost, rather than by DRG classification. We encourage Congress to look closely at the prospective plan's allowances for such atypical cases.

Need for guidelines for medical record departments

Proposed revisions to the Hospital Conditions of Participation would lengthen the time for record completion and delete the requirement for credentialed medical record professionals. In order for prospective payment to succeed, accurate and timely data is needed. We ask the Committee's support in retaining strict guidelines for medical record departments and their personnel.

Finally, we offer the expertise of the American Medical Record Association as a prospective payment system is designed.

STATEMENT

My name is Sally Simons, and I am the director of the Medical Record Department at Overlook Hospital, Summit, New Jersey, one of the original 26 DRG experimental hospitals. I am here testifying on behalf of the American Medical Record Association, an organization representing 25,000 medical record practitioners across the country. We are glad to have the opportunity to testify today and share with you our views on prospective payment and the concept of DRG's as spelled out in Secretary Schweiker's Report to the Congress in December of 1982.

In our role as medical record practitioners, we have several points we would like you to consider as the prospective payment system is developed. Medical record departments in hospitals have long been the source for clinical data reporting for all purposes—patient care, clinical research, epidemiological studies and third party payment. Now with the possible implementation of DRG's as a nationwide reimbursement mechanism for Medicare patients, data collection and reporting will be the supporting vehicle for the fiscal health of the hospital, not only directly for billing but also indirectly for management reporting. Such reporting is essential to both the Federal government and the individual hospital in order to address areas of inefficiencies in delivery of care, the overall purpose of the prospective payment plan.

We speak to these points based both on our experience with the New Jersey experiment which has utilized DRG's as the reimbursement method for all payors since 1980, and from our experience and expertise as medical record professionals whose training has long focused on data collection, classification, and reporting. Medical record practitioners have always been concerned that data reported are accurate and timely. Utilization of these data for reimbursement will not alter our pursuit of that objective. Because of these concerns, we ask you to consider the following points:

1. Data definitions

DRG's are calculated on certain variables: principal diagnosis, significant secondary diagnoses (hospital complications and other conditions which existed at the time of admission and which have an impact on the length of hospital stay), age, operative procedures, and other variables such as discharge status which are unique to certain DRG's. In developing any nationwide system, it is imperative that all participants understand the rules of the game and that the rules be clearly defined. The rules or terms for national clinical data reporting have been defined in the Uniform Hospital Discharge Data Set (UHDDS). The New Jersey experience has shown that even those terms need to be further clarified and expanded so no potential for misinterpretation or fraudulent use of data can enter into the reporting process. Some misunderstanding of terms surfaces in the Secretary's report on page 97 in differentiating principal from primary diagnosis. Such distinctions must be clearly defined or the potential for inaccurate reporting and data manipulation will exist. The variables must be defined in such a way that all mean the same to each institution reporting. We recommend adherence to the already established and disseminated definitions of the UHDDS.

2. Data collection

Consideration must be given now to how data are collected for the future. The MEDPAR data base, we feel, is seriously flawed because of the data collection methodology, a fact which the Secretary admits on page 93 of his report to Congress. The data were collected in a narrative form in hospital billing offices. Frequently this information was collected from the patient on admission to the hospital and was an inadequate picture of the patient's subsequent hospital course and resource consumption, information which can only be fully determined at discharge. Further, the data were classified at HCFA according to the ICD-9-CM classification system without access to either the source document—the meidcal record—or the treating physician. Additionally, the data fields on the MEDPAR bills were inadequate for total representation of the patient's clincial picture. The Secretary states that the data for establishing rates are inaccurate, but that the inaccuracy is of no consequence as it is to the hospitals' advantage. We feel strongly that a national system which could determine the future health of the nation's hospitals should be based on the best available data. Future data reporting, therefore, should be designed to obtain data from the source document—the medical record—by hospital-based personnel who are trained in ICD-9-CM classification and who have access to the treating physician for necessary diagnostic information.

3. Definition of case mix

DRG's are based on the theory that each DRG for which a rate is established is clinically coherent and thus an accurate predictor of resource consumption. Each DRG defines the product the hospital offers, and the DRG rate is the price for that product. However, there are some DRG's that, due to the nature of their composition, are not homogeneous in nature and thus cannot be an accurate predictor of price and are unsuitable for a prospective payment plan. In New Jersey, cases falling outside the system are termed outliers and are billed on the DRG rate. The Secretary's proposal allows only those cases with a very high length of stay to be considered outliers and to be paid more than the typical DRG rate. In New Jersey, we have found a number of other cases in which the experience is so unusual that no accurate prediction of resource consumption can be made and no rate generated. The cases are:

(*a*) Death (Patients who expire consume an abnormal number of resources.)

(*b*) Low volume outliers (There may be diagnoses in which the occurrence is too minimal to predict a rate, such as Legionnaire's disease.)

(*c*) Discharge status (Patients who leave against medical advice or are transferred to another facility are not reliable predictors of resource consumption.)

(*d*) Low outliers (Patients who stay well below the average length of stay are considered low outliers. Patients who could be treated in ambulatory care settings could be admitted as inpatients to gain the DRG rate if provision for low outliers is not included in the plan.)

(*e*) Clinical outliers (In New Jersey, we consider clinical outliers to be those DRG's into which a number of unrelated diagnoses and/or procedures are lumped. The diagnoses or procedures included do not necessarily relate to each other and are not accurate predictors of resource consumption. In New Jersey, these clinical outliers are billed on charges, not the DRG rate. As an example, one DRG included virtually any procedure performed in an operating room and unrelated to the prinicipal diagnosis, ranging from vasectomy to removal of a malignant brain tumor.)

We would encourage the Congress to look more closely at outliers if a clinically coherent system is to be established.

Finally, we would like to offer the assistance of the American Medical Record Association in the development of the prospective payment plan. The 467 ICD-9-CM DRG's were developed at Yale and refined in the New Jersey experiment with the assistance of clinicians and medical record practitioners who helped clarify data reporting and whose knowledge of coding and uniform definitions lent consistency to the data base used for rate setting.

Further, we are concerned that aspects of the proposed revision to the Conditions of Participation will be contradictory to the aims of timely data collection and reporting. Proposed revisions would extend the time for a history and physical from 48 to 60 hours after admission. The first hour of patient treatment are crucial, and to delay the documentation of basic patient health information could be a detriment to the quality of communication among those treating the patient, and to the efficient use of hospital resources. Second, the proposal would double the time, from 15 to 30 days, allowed for completion of the medical record. Such a delay will not only hinder the reimbursement process, but has the potential for encouraging less accurate information than that documented closer to the time of discharge. In addition, the proposed revisions would eliminate the requirement for credentialed medical record personnel in hospitals. Although we are sympathetic to the Administration's desire to give hospitals flexibility in the way they operate, we feel the presence of trained medical record practitioners is of such importance to the success of the prospective payment system that requirements must be maintained to have skilled personnel providing data to the Federal government. To eliminate the requirement is to allow hospitals to train medical record personnel themselves, a situation which could lend itself to inaccurate and unfair data reporting. We ask your support in retaining strict medical record requirements so the prospective payment system has the greatest potential for success.

I will be glad to answer any questions the Committee may have.

Chairman JACOBS. Mr. Moore.

Mr. MOORE. Thank you, Mr. Chairman.

I thank both of the witnesses for being here.

Ms. Simons, I think the DRG system will definitely make more important than before the function of your membership in keeping accurate records.

Thank you.

Mr. DUNCAN. No questions, Mr. Chairman.

Chairman JACOBS. The Chair expresses his gratitude also to the witnesses for their testimony.

Mr. Paul M. Long, chairman elect designate, Healthcare Financial Management Association, senior vice president and assistant treasurer, Burlington County Memorial Hospital, Mount Holly, N.J., and Mr. Harold O. Buzzell, president, Health Industry Manufacturers Association.

I will say for the record the reason that we are enforcing the 5-minute rule religiously is that those who testify at the beginning of the day are really privileged. They are called on first. Maybe we ought to have a better system for doing that, by lots or some other method.

In any case, the folks who come at the end of the day have to garner all these extra 3, 5, 4, 2 extra minutes that are taken up. So you are really taking the time of the witnesses who are following.

So the Chair will enforce the 5-minute rule, having explained it in less than 5-minutes, I hope.

Please proceed.

STATEMENT OF RONALD R. KOVENER, VICE PRESIDENT, HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

Mr. KOVENER. I am Ronald Kovener, vice president of the Healthcare Financial Management Association.

HFMA has more than 21,000 individual members who are financial managers of health care providers or who are closely associated with the financial managemant activities of the health care providers.

These members are involved in evaluating and implementing the medicare payment system and are therefore very interested in the Department of Health and Human Services' proposal for a medicare prospective payment system for hospitals. We have attached to our testimony general guidance on this subject that we have developed.

HFMA has long recognized the need for and has advocated adoption of a new financial relationship between health care organizations and Government. We applaud the Congress recognition that basic and fundamental change is needed.

The Secretary's proposal provides a good framework for discussion, but requires significant refinement to be acceptable. HFMA endorses the Secretary's proposal to determine medicare rates prospectively without provision for retroactive adjustments and to recognize case mix differences through use of a case price for each diagnostic related grouping.

We do not believe it is appropriate to start abruptly with a system based on national average DRG rates, however. The impact of national average rates on individual hospitals is not known.

We do know, however, that care patterns vary across our country for reasons we do not fully understand. We urge an evolutionary approach which initially bases the DRG price on each hospital's historic audited and verified medicare data.

These prices can gradually be converted to a national basis first on those DRG's with reasonably consistent patterns of resource consumption.

There also must be increased involvement of physicians. A major objective of any change in payment arrangement should be to influence demand for health care services, including modification of practice patterns. Physicians must be involved in the new payment system in a manner consistent with their role as gatekeeper to resource utilization.

There should be an opportunity for patient financial participation. Patient payment is important to influence demand and choice of services. Providers must be permitted to assess appropriate charges for additional or higher levels of care desired by beneficiaries, but in excess of that which is paid with Government funds.

It should not be necessary for hospitals to dissassociate from the medicare program to assure their fiscal viability or to be able to offer beneficiaries the level of service they desire. Patients' financial participation should provide financial resources when other economic or political priorities dictate limitaitons on funding by payers.

As has been explained by other speakers, the Secretary's proposal to deny providers access to courts to resolve disputes is completely unacceptable. Prompt, impartial, decisive dispute resolution and a process for dealing with exceptions are necessary.

HFMA members are intimately involved in all aspects of preparing the details of financial reports now required by medicare rules. We recognize the need for change in focus of detailed financial reports for payers.

We urge inclusion of all institutionally provided medicare services, including out patient services, in the new prospective payment system. Systems of controlled charges for out patient services can provide adequate safeguards for the Government while also providing a more integrated and cost effective system and significantly reducing paperwork.

Adoption of an inclusive payment system will greatly reduce the need for the detailed reporting. Payment must be made promptly.

The process for updating rates must be impartial and adequate for continuation of fiscally sound health care services.

Arbitrary limits and rates set by edict are not in anyone's long term interest.

In summary, we would like to reiterate HFMA's recognition of the need for prompt action to develop a new financial relationship between the Government and health care providers. The Secretary's proposal introduces many very desirable concepts and represents an important step in the right direction.

A number of changes are needed including:

Initial rates based on the institution's historic data.

Increased physician involvement.

Opportunity for optional patient financial participation.

Provision for judicial resolution of disputes.

Reduced financial reporting burden.

Compatible rate setting for out patients and other services.

Prompt and impartial updating of the rates.

Additional detail is in our written testimony. We appeciate the opportunity to present these views.

[The prepared statement follows:]

STATEMENT OF THE HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION PRESENTED BY R. R. KOVENER, VICE PRESIDENT

I am Ronald Kovener, FHFMA, CAE, Vice President of the Healthcare Financial Management Association. HFMA has more than 21,000 individual members who are financial managers of healthcare providers or who are closely associated with the financial management activities of healthcare providers. These members are involved in evaluating and implementing the Medicare payment system and are, therefore, very interested in the Department of Health and Human Services' proposal for a Medicare prospective payment system for hospitals. HFMA's "General Guidance Concerning Prospectively Determined Prices" is attached to our written testimony and serves as the basis of our testimony today.

HFMA has long recognized the need for, and has advocated adoption of, a new financial relationship between healthcare organizations and the government. In our view, the current system is based on complex and inconsistent rules and restrictive definitions of allowable cost. We do not believe the government is paying a fair share of the cost of serving Medicare patients, particularly costs of capital and charity services. The ever growing body of rules is excessively burdensome. We understand the government's concern that it cannot adequately predict and control its financial obligations under the Medicare program and that the system does not provide adequate incentives for cost effective operations by providers. For these reasons we applaud Congress' recognition that basic and fundamental change is needed. The Secretary's proposal provides a good framework for discussion but requires significant refinement to be acceptable.

It is also important to recognize that attention to new payment arrangements is only one of many steps needed to resolve concern about the cost of health care. The mutual objectives of all parties must be considered—patients, payors, physicians, providers and the public. Such mutual objectives should encourage cost effective demand and choice consistent with spending priorities of the entire economy, as well as of public funds. Similarly, promises must be in balance with commitment and ability to pay. A greater commitment to adequate funding of the government's promises must be evident in the Secretary's proposal. HFMA members cannot support a system which allows arbitrary payment decisions and at the same time demands that hospitals provide increased services.

HFMA endorses the Secretary's proposal to determine Medicare rates prospectively without provision for retroactive adjustment and to recognize case-mix differences through use of a case price for each diagnostic related grouping. We do not believe it is appropriate to start abruptly with a system based on national average DRG rates, however. The impact of national average rates on individual hospitals is not known. We do know, however, that care patterns vary across our country for reasons not fully understood. We also know that DRG data has many weaknesses such as inadequate recognition of severity, difficulty in handling outliers, in adding new DRGs or reflecting changing care patterns. Also, the fact that DRG data was collected for another purpose effects the reievence of the data to this new purpose. While we support use of the DRG data, we urge an evolutionary approach which initially bases the DRG case price on each hospital's historic, audited and verified Medicare data. These prices can gradually be converted to nationally-based prices, first for those DRGs with reasonably consistent patterns of resource consumption. During this evolutionary process, there must be a commitment to improving the quality and usefulness of the DRG data and this time can also be used to examine additional consumer choice/competition concepts such as vouchers and capitation.

There also must be increased involvement of physicians. A major objective of any change in payment arrangements should be to influence demand for healthcare services including modification of practice patterns. Physicians must be involved in the new payment system in a manner consistent with their role as gatekeeper to resource utilization. Some ideas are included in the "General Guidance . . ." attached to this written testimony.

There should be an opportunity for patient financial participation. As has been shown by research studies, patient payment is an important way to influence demand for healthcare services without discouraging provisions of essential services. It can also influence choice of services for example, it can encourage lower cost ambulatory or home service in preference to inpatient service. In addition, it can improve patients' understanding of services provided and their value; and permit patients to express their preference and priorities. Providers must be permitted to assess appropriate charges for additional or higher level care desired by beneficiaries but in excess of that which is paid for with government funds. It should not be necessary for hospitals to disassociate from the Medicare program to assure their fiscal viability or to be able to offer beneficiaries a level of service they desire. Patient financial participation contributes to accurate reporting to the patient and others of services provided and provides essential financial resources when other economic or political priorities dictate limitations on funding by payors. We stress providing latitude for this provider action recognizing that many, probably most, institutions will not choose this option initially, primarily because of the risk of bad debts and of public relations concerns.

As has been more fully explained by other speakers, the Secretary's proposal to deny providers access to courts to resolve disputes is completely unacceptable. Prompt, impartial, decisive dispute resolution and a process for dealing with exceptions are necessary.

HFMA members are intimately involved in all aspects of preparing the detailed financial reports now required by Medicare rules. We recognize the need for a change in focus of detailed financial reports to payors. The cost of preparing, submitting, receiving, processing, verifying, compiling, using and adjudicating these detailed financial reimbursement reports is very large. Eliminating these costs can contribute to achieving desired reduction in healthcare costs.

HFMA urges inclusion of all institutionally-provided Medicare services, including outpatient services, in the new prospective payment system. Systems of controlled charges can provide adequate safeguards for the government while also providing a more integrated, cost effective system and significantly reducing paperwork. Adoption of an inclusive payment system will greatly reduce the need for detailed reporting.

Rates must be updated no less often than annually and, must recognize inflation, and other economic and technological changes. Payments must be made promptly. The process for updating rates must be impartial and adequate to the continuation of fiscally sound healthcare services. Arbitrary limits and rates set by edict are not in anyone's long-term interest. Adjustments to compensate for forecasting errors should be promptly included on a prospective basis with consideration of the time cost of money.

While a system meeting the needs of all providers is desirable, there are special circumstances of small and rural providers. Because of these special circumstances, and because the financial impact of these providers is minor, optional participation by these providers in a new system, particularly its early phases, is appropriate.

Provisions for transition from the existing payment system are unclear. We believe a conversion to a DRG rate system based on each hospital's cost data can be made for all facilities on October 1, 1983, or at the start of the next following hospital fiscal year if enabling legislation and regulation work is completed promptly. We urge prompt action toward this goal.

In summary, we would like to reiterate HFMA's recognition of the need for prompt action to develop a new financial relationship between the government and healthcare providers. The Secretary's proposal introduces many very desirable concepts and represents an important step in the right direction. A number of changes are needed including: Initial rates based on each institution's historic data; increased physician involvement; opportunity for optional patient financial participation; provision for judicial resolution of disputes; reduced financial reporting burden; compatible rate setting for outpatient and other services; prompt and impartial updating of rates.

Chairman JACOBS. Thank you, sir.

Mr. Buzzell.

STATEMENT OF HAROLD O. BUZZELL, PRESIDENT, HEALTH INDUSTRY MANUFACTURERS ASSOCIATION, ACCOMPANIED BY WAYNE ROE, DIRECTOR OF ECONOMIC STUDIES

Mr. BUZZELL. Mr. Chairman, I am Harold Buzzell, the president of the Health Industry Manufacturers Association. This is a trade association representing nearly 300 manufacturers of medical devices and diagnostic products.

These companies include firms like General Electric, making big ticket items like CAT scanners and nuclear magnetic resonance machines; Baxter Travenol, making I.V. solutions and dialysis devices; DuPont, making a variety of complex devices like blood chemistry analyzers; and many other firms like Johnson & Johnson, Becton Dickinson, C. R. Bard, Pfizer, Abbott, and Warner Lambert, to name a few.

Yet, our high technology industry consists of entrepreneurs of all sizes. We also represent, for example, the small manufacturers of this country in this field. Over 200 of our members do less than $20 million a year in sales.

I am accompanied by Wayne Roe, director of research and economic studies at HIMA. We come here today with a full statement, but briefly would like to state really two things.

First of all, we support the concept that former Secretary Schweiker and the Department have forwarded to you of a medicare prospective reimbursement system.

Second, we also—as many of your other witnesses have done—recognize that the proposal has some flaws. Of particular concern to us are the issues dealing with medical product technology and with data recordkeeping and accounting systems that now exist.

We think your proposal, as you develop the legislation this year, should be based on six principles. I would just state those briefly.

One, prospective payment should stimulate provider productivity. Regardless of the various forms of design, in essence, it has to focus on hospital productivity—something that is currently not the case with the reimbursement system, as I am sure you recognize.

Two, it also should have a moderating effect on medicare spending.

Three, the system should assure quality health care and access to that care.

Four, prospective payment should reflect differing characteristics of the beneficiaries—for example age, sex, and health status.

Five, prospective payment in the long term should apply to all providers and beneficiaries. At some point in history you quite likely, will have to go beyond the medicare population. Also, at some point, off-site facilities—that is, nonhospital facilities—will have to be included.

Six and lastly, prospective payment should avoid undue regulation. The experience in New Jersey, which is the model this proposal is designed after, has some flaws and one of those is the undue regulation.

In terms of the medical technology, I would like to quickly point out that health care quality, as a number of witnesses have stated, could be jeopardized under this proposal. It certainly could be jeopardized if we inhibit the development of new technologies.

In this proposal, the Department sketches procedures for adjusting DRGs to reflect technological advances, but unless these procedures are carefully structured, the proposal could inhibit much of the research that fuels technological development.

This could limit availability of new diagnostic and treatment capabilities.

To adjust DRG's properly, the Department will need a substantial amount of information on technologies. The Department will need to determine early in the life of the technology if it is effective and, if so, for which cases.

Answering those questions will require understanding not only of the technology's cost at the time a patient is admitted to the hospital, but also the technological benefits to the patient and medicare over time.

As I said earlier, the other major flaw we see is the need for the proposal eventually to address the inadequacy of the accounting data that currently exists in our hospital system.

In conclusion, we would like to reiterate our support for the prospective plan and our support in general for the Department's proposal.

We will be happy to work with the committee and the Department to perfect the proposal so that it brings fiscal responsibility to medicare—something that is currently lacking—without inhibiting the development of new medical technologies.

I thank you, Mr. Chairman, for the opportunity to testify.

[The prepared statement follows:]

STATEMENT OF HAROLD O. BUZZELL, PRESIDENT, HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

Mr. Chairman and Members of the Subcommittee: My name is Harold O. Buzzell. I am President of the Health Industry Manufacturers Association (HIMA), a trade association representing 285 manufacturers of health care products.

HIMA commends this Subcommittee for its prompt consideration of a key issue—Medicare prospective payment. Over the last several months, prospective payment has been the subject of careful attention by the Health Care Economics Committee of the HIMA Board. We appreciate this opportunity to share our thoughts with you today.

After these hearings, you will have heard a broad range of views on prospective payment. Two points I want to stress about HIMA's testimony are these:

First, our industry supports the concept of Medicare prospective payment to replace the program's current hospital reimbursement system.

Second, we support, in general, the prospective payment plan submitted to Congress by the Department of Health and Human Services. We have concerns, however, about some aspects of the plan.

THE CONCEPT OF MEDICARE PROSPECTIVE PAYMENT

Need for reform of the current system

The current Medicare reimbursement system is seriously flawed. By paying costs already incurred, the system dispenses penalties to the productive and prosperity to the inefficient. These perverse incentives fuel escalating program costs—costs estimated at more than $57 billion for the current fiscal year.

Though the Tax Equity and Fiscal Responsibility Act (TEFRA) made significant changes in Medicare, the program remains flawed because hospital payments are still tied to costs incurred.

Principles for a workable prospective payment system

To correct flaws in the current reimbursement system, HIMA supports enactment of a Medicare prospective payment plan. We believe prospective payment should embrace six principles:

1. *Prospective payment should stimulate provider productivity.*—The system should contain incentives to encourage providers to reduce costs through increased productivity. The incentives should be positive—they should reward efficiency.

2. *The payment system should have a moderating and predictable effect on medicare spending.*—Our economy cannot support continued rapid growth in Medicare spending. Medicare should be restructured to moderate spending growth and assure that spending is predictable.

3. *The system should assure quality health care and access to that care.*—Despite its flaws, current Medicare reimbursement assures access to high quality care for the elderly and disabled. Prospective payment should encourage efficiency without sacrificing quality or access. Of special significance to HIMA is quality care made possible by advances in technology. Prospective payment should not stifle the research that produces new techniques, which, in turn, enhance the quality of health care.

4. *Prospective payment should reflect the differing characteristics of medicare beneficiaries.*—Prospective payment rates should reflect characteristics (such as age, sex, and health status) of the beneficiary populations whose care the system finances. Without considering these differences, the system might place undue burdens on beneficiaries with exceptional health care needs and providers that serve those beneficiaries.

5. *Prospective payment, in the long term, should apply to all health care providers.*—Prospective payment should promote efficiency in the health care system as a whole—not just in hospital inpatient settings. To encourage system-wide efficiency, prospective payment should eventually apply to all providers.

6. *Prospective payment should avoid undue regulation.*—The system should promote efficiency through financial incentives, not heavy-handed regulatory controls.

THE DEPARTMENT'S PROSPECTIVE PAYMENT PROPOSAL

HIMA commends the Department for its prospective payment proposal. If enacted, the proposal would make encouraging changes in Medicare.

Under the proposal, hospitals would be rewarded for shortening inpatient stays, restraining costs of labor and supplies, and reducing use of ancillary services. Improving productivity in these ways should moderate growth in Medicare spending.

While HIMA supports the Department's proposal in general, we have concerns about some aspects of it. In particular, we are concerned about the proposal's potential effects on new technology.

1. The proposal could jeopardize quality health care by inhibting development of new technologies

The proposal would establish fixed hospital payments that would differ according to Diagnosis Related Groups (DRGs). In computing the payment level for a given DRG, the Department would consider costs of caring for patients in that DRG, including costs associated with health care technologies. Since historical cost data would be used to compute the DRG rate, that rate would reflect use of established technologies, not new ones. The DRG rate would be like a snapshot in time—a snapshot depicting yesterday's technologies, not today's.

In the proposal, the Department sketches procedures for adjusting DRGs to reflect technological advances. HIMA believes that unless these procedures are carefully structured, the proposal could inhibit much of the research that fuels technological development. This could limit the availability of new diagnositics and therapies.

To adjust DRGs, properly, the Department will need substantial amounts of information on technologies. The Department will need to determine early in the life of a technology whether it will be effective and, if so, for which cases. Answering those questions will require understanding not only of the technology's costs at the time a patient is admitted to a hospital (the proposal's frame of reference), but also the technology's benefits to the patient and Medicare over time. If a technology eliminates a future hospital stay for a patient, for example, the Department should consider this benefit in its adjustment process.

HIMA offers its cooperation to the Subcommittee and the Department in developing the adjustments process. Our goal is to insure that this process will allow technology to continue to contribute to quality health care for Medicare beneficiaries.

2. Over time, the Department's data should be improved

Through DRG's, the proposal would fix Medicare payments per case. One important purpose for case-mix adjusted rates, according to the proposal, is "to match explicitly patient benefits with the costs of services provided to Medicare beneficiaries."

The Department's pricing methodology would use pre-TEFRA hospital accounting data to construct case prices. This data reflects hospital management and resource allocation practices intended to maximize reimbursement of costs. In many cases, these data reflect inter-departmental cross subsidies or charging schemes, which could cause faulty case prices under the Department's DRG system.

There are also other flaws in the Department's data. According to the National Academy of Sciences, for example, more than 30 percent of the Medicare cases the Department recorded in 1977 and 1980 contained errors as to primary diagnosis.

The combination of these flaws may produce case prices that cannot be economically matched by well-managed hospitals. To compensate for these potential problems, we urge that the Department's data be improved over time through the DRG adjustments process. Again, HIMA offers its cooperation.

CONCLUSION

HIMA reiterates its support for prospective payment and its support, in general, for the Department's proposal. We would be happy to work with the Subcommittee and the Department to perfect the proposal so it brings fiscal responsibility to Medicare without inhibiting development of new technologies.

Chairman JACOBS. Thank you, Mr. Buzzell.

Mr. Moore.

Mr. MOORE. Gentlemen, you both addressed the idea of allowing optional patient financial participation. You probably have heard the question I have asked other witnesses that will allow a more flexible DRG system where you would allow a hospital to charge more if there is a hospital in the same community that will charge the same or less than the DRG.

It would, it seems to me, allow for more patient financial participation. It may not be exactly what you are thinking about, but it is a difference from what the administration is proposing.

Do you think that it would work?

Mr. KOVENER. Healthcare Management Association would favor that approach certainly as an opening way. We believe that patients financial participation is an extremely important measure of patient preferences.

We know through research it—patient payment—is an important influence on demand and choice. We don't have any way of knowing whether our national resources are being directed properly if we don't have some measure of what people want. We can get an indication of preferences and priorities if we let patients pay something.

We don't know for example if patients want to avail themselves of new technology that the Government has for one reason or another decided not to pay for, but the people want it.

We need this kind of latitude of action for the patients through their pocketbooks to express their preferences about the payment for health care service.

Mr. BUZZELL. I would answer the question in this way and briefly.

One of our key principles in terms of the design of a DRG prospective system has to be the principle of productivity. We have to provide our hospitals with an incentive to be productive.

So, we lean in the direction of favoring a DRG system similar to the one used in New Jersey, where a fixed rate is established. And if, subsequently the hospitals incur more cost, then they in fact would have to bear that burden.

Conversely, if there is a positive variance, they get to retain that profit.

So, to preserve the principle of productivity, it seems to me it makes it important that we not deviate too far away from the concept of flat rate DRG's.

I am not sure if that answers your question.

Mr. MOORE. I think you are answering it. I think we are both looking at the same goal, but I am offering you something that you probably have not thought of before and that is the idea that if you have a hospital that is being very productive, there is no incentive now for it to post charges less than the DRG rate.

Therefore, it makes a bigger profit. I am hoping that a productive, efficient hospital, if we allow them to charge less than the DRG rate, would make that known to the public and attract those patients.

Mr. BUZZELL. I would agree.

Mr. MOORE. Likewise, a hospital that has a new device that it is using that is not cranked into the DRG system, yet would be allowed to charge a bit more.

Mr. BUZZELL. Many of the hospitals in this country have a marketing problem, not a quality of care problem, and not a productivity problem. They simply don't have enough of the market share. Coming from an industry that depends on the free enterprise system, we would favor a concept whereby the hospital could charge anything it wishes, as long as it wasn't above the DRG rate.

Mr. MOORE. Thank you very much.

Chairman JACOBS. Mr. Duncan.

Mr. DUNCAN. I have no questions. Thank you.

Chairman JACOBS. We thank the panel for its contributions to our deliberations.

American Medical Association, American Psychiatric Association, and Association of American Physicians and Surgeons.

I am sure, gentlemen, you have heard how our proceedings go.

STATEMENT OF JERALD R. SCHENKEN, M.D., VICE CHAIRMAN, COUNCIL ON LEGISLATION, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY ROSS N. RUBIN, DIRECTOR, DEPARTMENT OF FEDERAL LEGISLATION

Dr. SCHENKEN. Thank you, Mr. Chairman.

My name is Jerald Schenken. I am a physician in the practice of pathology in Omaha, Nebr., and am vice chairman of AMA's Council on Legislation.

The last time I appeared before you I think I won your silver dollar thing. I don't think I can quite do that again.

The American Medical Association is opposed to the implementation of any system of prospective pricing for hospital services unless the system is first proven through limited demonstration projects to be effective in both cost savings and retaining quality of health care.

A radical restructuring of the system of payment for hospital care by the implementation of an untried system of prospective pricing could reduce the quality of health care available.

In raising this point, two facts about the system must be stated. The principal purpose of prospective pricing is not to improve access or quality of health care, but to do reduce expenditures for hospital care.

The administration's proposal slated for implementation on a nationwide scale in October 1983 has never been tried even on a limited scale. While experiments for pricing have been conducted, these projects have examined only the question of possible program savings. They have not examined the long- and short-term impact of the payment methodology on the quality and accessibility of the care.

Regarding the administration's proposal, the American Medical Association has pointed out a number of readily apparent problems.

First, the proposal is planned for implementation for fiscal year 1984 without thorough testing and evaluation.

Second, the proposal fails to specify the methodology in establishing this national uniform rate.

Third, the proposal, unlike the New Jersey program, fails to recognize some of the legitimate variations in different institutions.

Next the proposal's use of DRG's as the case mix adjuster fails to recognize variations in the intensity of illness, impact of complications with DRG and so forth. Many of the witnesses have allowed to this fact.

The proposal does call for an annual update of DRG reimbursement charges for care, but changes in the intensity of care may not be appropriately considered.

Finally, the proposal fails to incorporate or allow for any appeals.

AMA recommends: A complex system with complex problems should not be addressed with untried solutions.

AMA recommends that this committee authorize demonstrations of the administration's proposal, the proposal of the American Hospital Assocation with modifications which we have indicated in our full statement and other appropriate prospective pricing proposals as well.

Analysis of these proposals when instituted on a limited scale and evaluation with present demonstration projects including the New Jersey experience will help in assessing the feasibility of implementing a new nationwide system for hospital reimbursement.

In conclusion, while the approach recommended by the AMA in our longer statement may not immediately reach the desired cost savings, it will not place the medicare beneficiaries at risk of losing access to quality medical care.

A moderate, reasoned approach in the development of a new payment methodology for the future that will create incentive toward cost savings could have the effect of preserving this quality of care that has been promised to the medicare beneficiaries while concurrently resulting in effective cost savings.

The details of our proposal are in our longer statement, Mr. Chairman.

We thank you for the opportunity of appearing.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION PRESENTED BY JERALD R. SCHENKEN, M.D.

Mr. Chairman and Members of the Subcommittee: My name is Jerald R. Schenken, M.D. I am a physician in the practice of Pathology in Omaha, Nebraska, and I am Vice Chairman of AMA's Council on Legislation. With me is Ross N. Rubin, Director of AMA's Department of Federal Legislation. The American Medical Association is pleased to have this opportunity to testify on the issue of prospective pricing for hospital services furnished to Medicare beneficiaries.

Mr. Chairman, the American Medical Association fully recognizes that today's hearings to discuss a new methodology for determining payment for hospital services is taking place not only because of rising costs but because of severe economic pressures and a rapidly growing federal deficit. I think it is safe to say that given increased economic growth, lower unemployment and higher federal revenues, the pressure would not be as great to restructure hospital reimbursement so radically. The radical nature of the proposed restructuring cannot be stressed too strongly because the changes proposed will have a long-term effect on health care delivery beyond the Medicare program.

There is no doubt that the American people now spend a very significant amount on health care services. This is because the Medicare program was created in 1965 as a vehicle to increase resources devoted to health care for the elderly by improving access to high quality care. The program has been a tremendous success in providing health care services which are unparalleled anywhere in the world. However, the economic problems facing this country are real, and you are faced with many difficult choices. In order to look at rising hospital costs under Medicare, Congress mandated the Secretary of the Department of Health and Human Services (HHS) to develop for presentation to the 98th Congress a proposal for prospective pricing for hospital services.

In appearing before you to discuss the proposal presented by the Secretary, we ask that you keep two thoughts in mind:

(1) The principal purpose of prospective pricing is not to improve access to or the quality of health care in the United States; and

(2) The Administration's proposal, slated for implementation on a nationwide scale by October 1, 1983, has never been tried, even on a limited scale.

While the American Medical Association is concerned about the increase in hospital costs, we are also concerned about the quality of care that would be available to

Medicare beneficiaries under the extreme modifications proposed. Short-term budgetary solutions that do not assure continued availability of quality health care should not be viewed as viable alternatives if the program goal is to maintain a single sytem of health care that offers all Medicare beneficiaries access to quality health care.

The American Medical Association supports the development and exploration of systems for payment to institutions on the basis of predetermined rates or other payment systems that create incentives for facilities to be more cost-conscious. The American Medical Association has recognized the need to consider alternative forms of hospital reimbursement. In early 1978 the AMA adopted a recommendation of the National Commission on the Cost of Medical Care calling for the exploration of systems for payment to institutions on the basis of predetermined rates or other payment systems that create incentives for facilities to be more cost conscious. In accepting this recommendation, we pointed out that such systems should be implemented on a broad scale only if they prove to be effective. It would be inappropriate to institute a radical change in the Medicare hospital reimbursement system without assurances that quality care will be maintained. To this end, we strongly caution against the implementation of any full-scale prospective pricing system without experimentation and until ongoing projects have been analyzed to determine their effects on costs and quality.

DEMONSTRATION PROJECTS

"Prospective reimbursement" experiments have now extended over a period of some ten years, and the prospective systems have been both criticized and extolled over the years. Depending upon the forum, these characterizations have varied in degree. What has become apparent, however, is the lack of adequate analysis of the various "experiments" that have gone on to date. Moreover, studies of the various state systems with prospectively determined payments have examined only the question of possible program savings; they have not examined the impact of the payment methodology on the quality of care.

For example, an analysis of the hospital payment programs in the states of Arizona, Connecticut, Indiana, Kentucky, Maryland, Massachusetts, Minnesota, New Jersey, New York, Rhode Island, and Washington in the Winter 1981 issue of Health Care Financing Review (a publication of HHS) points to varying levels of savings generated in each of these states. However, this very study also points to a most significant flaw in the research to date on prospective pricing: the research fails to answer the important questions concerning how the reimbursement mechanism has affected the quality of care available. The study concluded with the following statement:

"We have examined only part of the evidence that deals with the effects of prospective reimbursement programs, and the *results we presented in this paper are preliminary*. In later phases of the national hospital rate-setting study, better data will be available for analysis, and we will undertake a much more comprehensive examination of program effects. *Until an analysis has been made of the effects of prospective reimbursement programs on the quality of care, on the accessibility of hospital services, and on the financial viability of hospitals, the information necessary for sound policy decisions is not complete.*" (Emphasis added.)

It is thus clear from this statement that the HCFA study is still ongoing even as to costs. In addition to the fact that the existing demonstration projects and studies have failed to measure changes in quality, recent statistics raise questions about the ability of prospective pricing systems to maintain program savings. As reported in the April 16, 1982, issue of Hospitals, the percentile change of annual hospital expenditures per capita has shrunk from a 4.3 point spread in 1978 between states with mandatory rate controls and other states to a mere 0.1 point spread in 1980 in favor of states with mandatory controls.

While prospective pricing programs in various states appear to have had some success in holding down the rate of increases in the cost of hospital care in comparison overall with states without prospective pricing, this one factor does not tell the whole story. In reality, states that have already imposed rate-setting schemes did so largely because of unacceptable costs experienced within those states. Those states, therefore, had high costs built into their prospective systems. By way of illustration, per capita hospital expenditures for states with mandatory programs was $250 in 1976 versus $196 for all other states. In 1980 the mandatory states had a rate of $373 compared to $329 for the other states. to compare only the rate of increases in mandatory states with those in other states is inappropriate. Yet this has been the primary measurement.

In addition to these concerns, recent statements from the Department of Health and Human Services indicate a puzzling lack of consistency of view on prospective pricing systems. As noted above, HCFA on the one hand has stated a need to examine further these programs to ascertain their effect on costs and on the quality of care. On the other hand, Secretary Schweiker on October 8, 1982, published a notice in the Federal Register expressing his view that no more demonstrations are needed except for prospective pricing systems with reimbursement based on Diagnosis Related Groups (DRGs).

Mr. Chairman, from these seemingly contradictory statements it is apparent that none of these former projects would be viable for nationwide implementation at this time. Instead, it appears that HHS has proposed a new system—the only system, however, that by its own admission needs further demonstration.

It should be noted that states with mandatory review programs have not all experienced satisfactory results. Massachusetts, one of the early rate-setting states, has now been forced to create a new system because the costs were too high. A rate review system was totally scrapped in Colorado. Illinois, after preliminary development, also scrapped its program. After the implementation of strict rate-setting in New York, a rash of hospital bankruptcies and closures has taken place as hospitals exhaust endowment funds, defer bill paying and take other drastic measures. As a result of operation of the New York system for over a decade, 81 percent of that state's hospitals were operating at a loss in 1980. The combined operating losses for that year totalled $256 million compared to a combined surplus of $16 million for the remaining hospitals. Conditions in New York City deteriorated to the point that the federal government had to step in to bail out failing hospitals that served large inner-city populations.

THE ADMINISTRATION'S PROSPECTIVE PRICING PROPOSAL

The Administration has not presented its proposal for prospective pricing for hospital services in legislative form. These comments are based upon the report to Congress by the Secretary of HHS in response to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Public Law 97-248.

Rate setting and payment

Under this proposal, prospective rates for inpatient hospital services to Medicare beneficiaries will be set in advance and fixed for all inpatient services on an annual basis. These rates will serve as payment in full for inpatient hospital services, with program beneficiaries being responsible for only statutorily-set deductible and coinsurance amounts. When hospitals receive a payment that is greater than the costs of treating Medicare beneficiaries, they will keep that "bonus," and they will be at risk where treatment costs are greater than the payment rates. Payments amounts would be updated annually.

Payment will be on a per-discharge basis. The initial year payment figure will be determined by a formula where base year costs are established for all hospitals "on a national representative Medicare cost per discharge." This will establish a single national representative cost per discharge. The report from the Secretary fails to state at which level this "representative" cost will be set. To recognize hospital case mixes, actual payment rates will be determined by adjusting the national cost-per-discharge rate by a factor assigned to each of 467 Diagnosis Related Groups (DRG). For example, if the national discharge rate is $3,000, and the DRG intensity factor for the diagnosis is 3, then the hospital's Medicare reimbursement will be $9,000. This will therefore create 467 national reimbursement rates. Adjustments will be allowed only for regional variations in labor-related costs.

Excluded costs

Capital costs and direct costs of medical education will continue to be separately reimbursed on a reasonable cost basis, and outpatient department costs will be calculated separately from the DRG system. Indirect educational expenses (expenses related to additional tests and the particular types of patients attracted to teaching hospitals) will be reimbursed to the hospital on a lump-sum basis.

DRG classifications

The DRG classification system will be the 1981 methodology developed at Yale University. This system groups patients into 467 categories derived from 1.4 million discharge records. Additional payments above the DRG rate will be authorized for extremely long-stay cases based upon "outlier" "trim points." Trim points will be determined by a review of patient stay data.

Exceptions

The proposal will not cover hospital services for those health maintenance organizations operating on a risk basis. In situations where a community is served by a sole hospital provider, the Secretary will be authorized to make appropriate exceptions and adjustment to the DRG rates for these hospitals. Payment amounts, exceptions, adjustments, and rules to implement the system would not be subject to any form of judicial review. Psychiatric, pediatric, long-term stay hospitals, and skilled nursing facilities would not be covered by the proposal.

SPECIFIC CONCERNS OVER THE ADMINISTRATION'S PROPOSAL

Mr. Chairman, we have numerous concerns about the Administration's proposal. Without question, a system can be devised to achieve any targeted level of cost savings over the existing system. The General Accounting Office pointed this possibility out in a letter report to Senator Packwood on May 10, 1982 (No. HRD-82-73). This report stated:

"A prospective system can be designed to achieve almost any level of program savings desired by selecting the appropriate set of rules. However, there is a point when a reduction in reimbursement could adversely affect access to and/or quality of care for beneficiaries. Also, if the prospective reimbursement does not apply to all payors, a facility can have an incentive to shift costs to non-covered payors."

We agree with the GAO's conclusion that any proposal, including the Administration's, could reach that point where there will be an adverse effect on access to and on quality of care for Medicare beneficiaries. From our review of the Administration's proposal, a number of readily apparent problems relating to quality of care are raised:

The proposal fails to specify the methodology for the establishment of the national uniform rate. What is to assure that this rate will be adequate? Will this rate be arbitrarily established based on a predetermined cost savings figure?

The proposal, unlike the New Jersey program, fails to recognize legitimate variances in different institutions. This could result in situations where individual hospitals will have to operate at the lowest common denominator.

The proposal's use of DRGs as the case-mix adjuster fails to recognize variations in the intensity of illness and the impact of complications within each DRG and the variations in services needed to address these cases. While the proposal recognizes "outlier" cases, it does not contain any explanation of the methodology for determining outlier cases, and it does not discuss the level of reimbursement for such cases.

The proposal would provide windfall reimbursement levels to some hospitals by providing them with reimbursement above the cost of providing services while causing substantial disruption of services in those hospitals whose actual costs are above the national average.

While the proposal does call for annual updates for DRG reimbursement, factors pertinent to the provision of care and central to maintaining and improving quality such as changes in intensity and new technology may not be considered. The potential also exists for the Secretary of HHS actually to dictate practice standards of care for Medicare beneficiaries by arbitrarily setting DRG rates at a level that fails to recognize changes and advances in medical practice. By way of example, we wonder whether the Secretary would alter the DRG payment in a situation where a new care regimen is developed that may better meet the needs of the individual patient but may be more expensive than the previous regimen of care.

The proposal fails to incorporate or allow for any appeals. We must question what recourse hospitals will have if DRG rates prove inadequate to meet their actual needs.

To operate a prospective pricing system most efficiently, hospitals will require a sophisticated reporting and accounting system. Will small hospitals be at a disadvantage? Will start-up money be authorized to develop techniques needed to manage the system?

As the proposal does not cover hospital outpatient services, will hospitals attempt to "unbundle" services by having services performed through their outpatient departments? Would hospitals have an incentive to bill separately for services previously performed on an inpatient basis and considered part of the normal course of treatment if those services are furnished in the outpatient setting prior to admission?

The proposal is planned for implementation without thorough testing and evaluation.

AHA PROPOSAL

The American Hospital Association (AHA) has also proposed a plan for prospective pricing under Medicare for hospital services. It has many features similar to the Administration's proposal, including a fixed cost per discharge and case weighting based on the use of DRGs. However, there are major differences that include the use of each hospital's cost base for establishing the reimbursement rate, the ability of hospitals to bill patients for charges not covered by Medicare in addition to Medicare mandated copayments and deductibles, and coverage of the hospital's outpatient department under a usual, customary and reasonable charge basis using each hospital's outpatient department costs as the basis for charges.

The AMA has some of the same concerns about the AHA proposal as it has about the Administration's. There is merit, however, is experimentation with the proposal, including the prospective pricing based on individual hospital experience. This method for establishing base-line price determinations could avoid the problems arising from use of nationally applied DRG's. We are concerned that the AHA plan would create serious inequities and disparities among hospitals and beneficiaries. The plan has the potential for creating a two class hospital system, with disruption in the physician-patient relationships.

We are also concerned with the proposal to reimburse outpatient departments on a charge basis using the hospital cost of providing such a service as the basis for reasonable charges. This proposal would not create an incentive for use of the least costly appropriate setting for furnishing outpatient services. The Omnibus Budget Reconciliation Act of 1981 called for similarity of payment for similar services furnished in hospital outpatient departments and physicians' office.

THE NEW JERSEY SYSTEM

We realize that some will point to the New Jersey hospital payment experiment and indicate that this is adequate proof that the health care system in this nation will not be harmed by a system of prospective pricing based on a DRG concept. However, we must point out that the system in place in New Jersey is just now being fully implemented and starting to be evaluated. Furthermore, regardless of the outcome of the analysis of the New Jersey program, it is important to realize that this system is very different from the Administration's proposal. First of all, the New Jersey system covers all payors, with all payors being responsible for approximately equal payments for similar services. In addition, the New Jersey system was implemented in a state that does not have a single small hospital with a bed population under 100. The New Jersey system also has other significant differences between it and the Administration's proposal. By way of example, the New Jersey system is based on a statutory commitment to cover all reasonable hospital costs, and the New Jersey system recognizes and allows for increased hospital compensation if the initial DRG rate determination provides inadequate revenue. To date, not a single hospital has accepted the initial DRG determinations as final payment for services. The Administration's proposal, on the other hand, sets a fixed price with no basis for appeals and is not concerned about the financial viability of the nation's hospitals.

The "Overview" of a study being conducted by the Health Research and Educational Trust of New Jersey indicates that "there is considerable uncertainty regarding the system's ability to contain costs." While this study is just in its initial stages, as is the New Jersey reimbursement system itself, it hopes eventually to answer the following questions:

Is the system properly designed and does it work as anticipated?

Does the system make a difference in terms of the hospitals' overall performance, effectiveness, and efficiency in providing medical care?

What is the system's potential as a regulatory device, management information or data-based planning mechanism, and utilization review tool?

What are the advantages and disadvantages associated with DRG reimbursement for hospitals, third-party payors, and others?

We note that the Congressional Budget Office is not conducting a detailed study of the Administration's proposal and that any actions should await the release of CBO's report.

We are concerned that the Administration's proposal would create an inadequate reimbursement system that would foster a two-tiered system of health care in this country, with one level of care for private-pay patients and a lower level of care for Medicare patients. The proposal contemplates that Medicare will not bear its fair share of financial responsibility for indigent patients, and the potential would exist for some hospitals to discourage acceptance of such patients. Such a payment system will place hospitals with large indigent patient loads in a situation where they will find it increasingly difficult to stay open.

Given the fact that the Administration's proposal is dissimilar from any of the ongoing demonstration projects and even from the New Jersey program, we believe it would be highly imprudent to go forward and implement a totally new national system of prospective pricing for all in-hospital care furnished to Medicare beneficiaries.

RECOMMENDATION OF THE AMA

Mr. Chairman, the American Medical Association recognizes that the rationale behind moving toward prospective pricing for hospital services is to reverse incentives that fail to encourage hospitals to deliver care in the most efficient manner possible. As previously stated, the American Medical Association endorses experimentation with prospective pricing methods. However, we firmly believe that such methods should not be implemented on a broad scale unless they prove to be effective. We urge you to consider this reasoned approach, and we recommend that this Committee reject the Administration's proposal to impose an untried system across the nation.

It is important to remember that decisions made in the near future concerning how hospitals and other providers under the Medicare program are reimbursed will have long-range implications on access to and the quality of care for years to come. We fully expect that hospitals, through their boards, administrators, and medical staffs, will all respond to changes in the reimbursement system in order to try to maintain access to and quality of care. In our view, if a system under Medicare and Medicaid under-reimburses hospitals, we can expect adaptations to such under-reimbursement by shifting costs to other payors, deferring costs such as maintenance (often leading to higher long-term costs), reducing nursing and other essential patient care staff, and postponing or eliminating necessary modernization and technological improvements (depriving patients of the highest quality of care). In extreme cases hospitals providing essential care could be forced to close.

Complex problems and complex systems should not be addressed with untried solutions. The American Medical Association recommends that this Committee authorize the Administration's proposal and other prospective pricing proposals to be demonstrated on a limited scale in various states. Analyses of these proposals, as tested, the present demonstration projects, and the New Jersey program will help in assessing the feasibility of implementing a new nationwide system for hospital reimbursement.

In recommending the continuation of ongoing demonstration projects and instituting new demonstration projects for prospective pricing for hospital services, we realize that the immediately sought goal of program savings may not be fully achieved. However, considering that the Medicare program is one designed to provide health care to millions of American people, we feel it appropriate that the quality of that care be placed ahead of potential dollars to be saved. In calling for futher demonstrations on prospective pricing, we realize that many hospitals could suffer adverse effects if the Section 223 limits now in place are allowed to be ratcheted-down over the next two years. As tightening of the Section 223 limits over the next two years could also adversely affect the quality of care available, we recommend that the Congress either repeal the provision of TEFRA that would lower the Section 223 limits from 120 percent of the mean to 110 percent of the mean or delay the scheduled timetable for reaching the 110 percent level. We also recommend that during this period the "target rate" incentive remain in place, and that it be modified to allow adjustments and waivers necessary to meet the unique circumstances that hospitals in various regions or categories face.

While these program changes would not result in the same level of cost savings projected in TEFRA, the Section 223 limits would still apply to all inpatient hospital services, and the incentive target rates for determining maximum allowable operating costs would continue to be in place.

CONCLUSION

The American Medical Association recognizes the tremendous task that is before you. On one hand is the huge budget deficit and the compelling need to find means by which to reduce that deficit. On the other hand is your responsibility to maintain the quality of care available to the American people. The AMA is opposed to the rationing of needed medical care for cost containment purposes; and we are equally opposed to restricting access to advances in technology that can be demonstrated to save lives, alleviate suffering, prevent disability and enhance the quality of life. A radical restructuring of payment methodologies for hospital care could cause these negative results.

Mr. Chairman, the Administration's proposal has no track record. No experiments have been undertaken. There are no assurances that it will be effective, and it creates the significant possibility of providing windfalls to some hospitals and diminishing the quality of health care available to Medicare beneficiaries as the program progresses.

I point out the above to stress that with the validity of the Administration's prospective pricing as an appropriate nationwide reimbursement system so seriously in question, the nation cannot afford the risks involved. We strongly urge that further demonstrations go forward before any attempt is made to alter so radically the manner in which payment is made for hospital care.

We urge you to consider carefully the questions raised in this testimony in your consideration of prospective pricing proposals. Continued demonstration projects and thorough analysis can lead to the development of a responsible and effective prospective pricing methodology. While this may not immediately reach the desired cost savings, it will not place Medicare beneficiaries at risk of facing a loss of quality medical care. A moderate, reasoned approach in the development of a new payment methodology for the future that will create incentives toward cost savings could have the desired effect of preserving the quality of care that has been promised to Medicare beneficiaries, while concurrently resulting in effective cost savings.

I will be pleased to respond to any questions the Committee may have.

Chairman JACOBS. Thank you.

Dr. English.

STATEMENT OF JOSEPH ENGLISH, M.D., CHAIRMAN, COUNCIL ON STANDARDS OF PRACTICE AND ECONOMICS OF PSYCHIATRIC CARE, AMERICAN PSYCHIATRIC ASSOCIATION, AND DIRECTOR, DEPARTMENT OF PSYCHIATRY, ST. VINCENT'S HOSPITAL & MEDICAL CENTER, NEW YORK CITY

Dr. ENGLISH. Thank you, Mr. Chairman.

I am Dr. Joseph English, chairman of the department of psychiatry at St. Vincent's Hospital. Our department of psychiatry is part of a voluntary teaching hospital in Lower Manhattan and it provides 60,000 days of in-patient care to psychiatric patients and roughly 100,000 outpatient visits to such patients each year.

I am here to speak on behalf of the American Psychiatric Association representing some 27,000 psychiatrists nationwide and thousands of patients who would be affected by the changes proposed in this reimbursement methodology before you today.

The most important thing, Mr. Chairman, we would like to say to you is that we commend the Secretary's excluding of private psychiatric hospitals from the DRG system. To quote from the Secretary's statement:

> The DRG data were not developed, tested or applied in these types of facilities. Nor do the DRG's group the case types and associated resources expended by these types of institutions.

So we think it is quite appropriate that private psychiatric hospitals have been excluded from this plan. For the same reason, we cannot understand why, inadvertently the administration included general hospital psychiatric beds.

There are more than 32,000 of these beds in the United States. Despite the fact DRG methodology has not been tested in general hospital psychiatric units or in private psychiatric hospitals, these general hospital psychiatric units have been included in the proposal before you.

We would like for that not to occur until an equivalent study has been made for these kinds of patients as was done in the Yale studies for other patients.

We also think this is important for psychiatric patients because length of stay is often not the best determinant of appropriate utilization of psychiatric service. For psychiatric patients other factors such as severity of illness, functional impairment and adequacy of support system outside of the hospital may be equally important.

The diagnosis of schizophrenia could result in one patient having one brief hospital stay, and another patient a lifetime of hospital care. It is very important for equivalent studies to be made of the needs of these patients.

We would also echo the concerns already mentioned in earlier testimony concerning the quality of care. For example, GAO pointed out to Senator Packwood that there is a point when reduction in reimbursement can affect access to and quality of care.

We would hope the committee would urge the administration to emphasize quality of care in the demonstration studies underway in addition to cost effectiveness.

We are also concerned about the effect on liaison psychiatry. Let me suggest why disincentives to this service could adversely affect costs of care.

There are several studies we would like to submit with our formal testimony which indicate that patients who have had surgery for hip fractures, and have available to them liaison consultative psychiatry service, can have their length of stay reduced on average from 42 to 30 days—a 29.6-percent reduction. This is an improvement in the quality of their care as well as being cost effective.

We don't know what the fate of these liaison services would be under the proposed prospective payment methodology.

We also share concerns relating to cost shifting that have been expressed by others at this hearing.

There are other possible detrimental effects that should be considered. For example, the arbitrary shortening of stays of psychiatric patients encouraging the revolving door effect. We are worried about pressures to extend hospital stays for psychiatric patients so that they can qualify for outlier status.

Finally, we are very concerned about the bureaucracy that this methodology could spawn. We know something about that in New York where a recent study by the Hospital Association of New York State demonstrated 25 cents out of every $1 spent for health care in New York State supports the regulatory bureaucracy.

We have other initiatives that we think are less arbitrary. They are in our formal testimony.

I appreciate this opportunity.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION PRESENTED BY JOSEPH ENGLISH, M.D.

Mr. Chairman and members of the Subcommittee: My name is Joseph English, M.D., and I am Chairman of the Council on Standards of Practice and Economics of Psychiatric Care of the American Psychiatric Association. I am also Chairman of the Department of Psychiatry at St. Vincent's Hospital and Medical Center in New York City.

I am pleased today to have this opportunity to testify on behalf of the American Psychiatric Asssociation, a medical specialty society representing over 27,000 psychiartrists nationwide, on the issue of prospective payment for hospital services, an issue which affects—directly or indirectly—countless numbers of individuals now diagnosed or to be diagnosed as mentally ill and many more individuals with a serious physical illness and a complicating mental disorder.

At the outset, it is improtant to note that the APA shares Congress' concern with the spiraling cost of both public and private sector health care delivery, particularly in this time of budgetary crisis in the Social Security system and high unemployment. We believe, as does the AMA, that the public and private sectors must seek answers not only to the question of medical care cost, but also to the equality pressing question of access to quality medical care. It is incumbent upon us to reconcile both of these issues, without compromising either.

We recognize that the prospective payment approach outlined by the Secretary before the Committee just two weeks ago is one solution to run-away Medicare costs, just as "catastrophic health insurance" plans were several years ago, or "hospital containment" was in the not-too-distant past. However, as then, we must caution. Implementation of a nationwide program—whether under Medicare and/or Medicaid, or stretching further to an "all-payor" approach—without a full evaluation of an adequate number and range of demonstrations is imprudent. We urge evaluation to include looking at the impact of the demonstrations' payment methodology on the quality of care, not looking simply at cost-efficiency studies. We note, for example, last year's Government Accounting Office letter report to Senator Packwood (May 10, 1982) which noted: "There is a point when a reduction in reimbursement could adversely affect access to and/or quality of care for beneficiaries." The only recent data bearing on this issue and cited in the Secretary's Report on prospective payment, are preliminary at best, and sample only 59 DRG categories. the preliminary findings of the Abt Associates report did not address the question raised in the GAO report, nor do other evaluations of prospective payment systems to date.

Thus, Mr. Chairman, we do not, today, know what that turning point of reimbursement versus quality of care is.

We commend the Secretary for his thoughtful and deliberate exclusion of private psychiatric hsopitals (and a number of other facilities) from the proposed DRG prospective payment system. We are gratified that he has recongnized that DRG data were not "developed, tested, or applied in these types of facilities, nor do the DRG group the case types and associated resources expended by these types of institutions."

There is, however, an anomoly here. While psychiatric hospitals per se have been excluded—at least until an appropriate DRG profile can be developed and tested—psychiatric units of general hospitals are clearly part and parcel of the proposed system. They are included nowwithstanding the apparent admission by the Yale team that the 14 psychiatric diagnostic groupings contained in the Yale-developed DRG listing to be utilized under the measure, were themselves never validated in any setting, whether general hospital, general hospital psychiatric unit, or private psychiatric facility. We understand further that these 14 groupings have neither been subject to serious scrutiny in the New Jersey prospective payment experiment, or any other utilizing the Yale schema.

How, then, can this listing be seen as a valid and reliable measure of either the nature of a psychiatric diagnosis made in a general hospital, or a tool from which the Administration can calculate a fee schedule?

The validity of this listing is particularly critical for psychiatry where diagnosis per se is not always a good predictor of utilization and therefore of cost. Issues such as the severity of illness, not necessarily adequately encompassed by the DRG system, are of particular import in treating the psychiatric patient. In short, to badly quote Gertrude Stein, it is not always the case that "a psychotic is a psychotic is a psychotic."

Data have recognized wide disparities in length of stay for psychiatric patients—both across type of facility and across diagnosis. This can be attributed to a variety of causes, including those regional variances cited by the Secretary, but also including the severity of the illness itself. We know, for example, that there is a significant difference between the length of stay for the psychiatric patient between the general hospital psychiatric unit and the psychiatric bed in a smaller general hospital. The DRG system would utilize an average length of stay to calculate payment. This does not appear to be clinically sound reimbursement practice. It could be likened to providing the same base payment to a hospital which provides treatment to a coronary patient in a coronary care unit as contrasted to treatment in a general ward capable of providing coronary care. They are simply not comparable.

Yet another aspect of the length of stay issue as it effects the psychiatric patient relates to the availability of an outside support system for the patient. In New York, for example, absent such a support system, a patient may require a greater length of stay until either an appropriate home-based care system can be found, or a long-term care facility bed becomes available. The lower the level of outside support, as a whole, the more likely the longer the stay. The DRG system ostensibly factors in "routine treatment" with "complications." However, at what point does the routine become a complication, and moreover, at what point does a "complication" become an example of an "outlier" case, and therefore reimbursible at cost?

These questions are difficult to answer with respect to those portions of the DRG listing which have been tested and validated adequately. They are nearly impossible to determine with accuracy for the 14 psychiatric categories which have not necessarily been subject to appropriate validation to date.

Without such validation, we would urge extreme caution and recommend against applying the DRG system at this time to psychiatric patients in any setting, not just those now proposed for exemption under the Adminstration's program.

We understand that the Administration plans to study how to bring psychiatric hospitals and other exempted categories under the proposed DRG plan in the future. We believe that treatment patterns for psychiatric patients as a whole including serious review of the "severity" issue—regardless of their treatment setting—should be reviewed carefully before being included under the DRG plan.

At the same time, we recommend that the Administration specifically and carefully scrutinize the so-called "outliers" within the proposed program—the high-cost users of hospital-based services—with an eye toward developing a more responsible, cost-effective means of managing such patients. We note, for example, that the costs of what has become known as "liaison psychiatry" would not necessarily be factored into a DRG reimbursement scheme, yet liaison psychiatry has been found in a growing number of studies to be a cost-effective, length-of-stay-reducing pattern of practice. Levitan and Kornfeld, for example, have found that in a year-long comparison of the post-operative course of a group of 24 elderly patients who had undergone surgery for repair of hip fractures and who had available liaison psychiatric services with a similar group for 26 patients who had the same kind of surgery but did not receive the liaison services, the group receiving psychiatric liaison care required an average of 12 fewer days of hospitalization (30 versus 42 days—a 28.6 percent reduction). This resulted in an estimated savings of $193,000 over the course of that year (with the liaison services costing $10,000 for the same year). Moreover, twice as many patients who had psychiatric liaison services were able to return home rather than to nursing homes or other less cost-efficient institutional settings.

Similar findings were made by Mumford, Schlesinger and Glass in a review of 34 controlled studies investigating the effect of psychotherapy interventions on recovery from surgery and heart attacks. Their review found that on the average, psychotherapeutic intervention reduced hospitalization approximately two days below a control group's average of 9.92 days.

Mr. Chairman, I have appended these studies to my testimony and ask that they be made part of the hearing record.

We believe that interventions, such as provided by liaison psychiatry, could be lost as the result of the imposition of the DRG system which would not include such costs as part and parcel of routine medical treatment for a physical disorder. They are found to be cost-effective and a factor in legitimately reduced lengths of stay. They should have a place within the system, if it is to be enacted.

Yet another aspect of the "outlier" or high utilizer concept which has been identified in the literature is the fact that patients with untreated mental disorders are high users of medical care and that a secondary disgnosis of mental disorder often leads to an increased utilization of other medical care—more often than not, repeated hospitalization. Under a DRG system, a hospital would have the opportunity to charge for treatment of a primary illness (the one for which the patient was actually hospitalized) or for the treatment of the secondary mental illness. Clearly, the higher-priced code would be chosen—the physical disorder, again notwithstanding the fact that the treatment of and therefore reimbursement for the secondary mental illness could have actually saved other hospital-based health care costs.

I will turn to issues such as those implied by the foregoing paragraph, including issues of code manipulation, cost-shifting, multiple admissions, etc., in a moment. However, there is one potentially pernicious impact of DRGS which needs to be addressed in somewhat greater length: its impact upon technology development and health research.

Secretary Schweiker noted in his Report on Prospective Payment that PPS "will encourage hospitals and physicians to develop convincing evidence that costly new technologies are both efficacious and cost-effective . . . allowing new or more costly patterns of care to be introduced in a more systematic and deliberative fashion." The fallout from such a policy could be seriously damaging this nation's biomedical and behavioral research community, and ultimately to the patients who might benefit from such breakthroughs in technology. In the past, psychiatry has not been in the vanguard of technological advances. However, today, we are upon the threshold of major breakthroughs in the diagnosis and treatment of dementia, of Alzheimer's disease. The PET scan—the brain related relative of the CAT scan—is now in prototype form. As both research outcomes and technology become increasingly available in our field, how can we be certain that these breakthroughs will have their appropriate and necessary impact upon the hospital-based practice of psychiatry under the current DRG proposal? Who will weigh the value of successful treatment against the cost of equipment? Who will determine a particular new technology's "cost-efficiency"?

Much of the current technological advance being made in psychiatry is aimed directly at the most chronic of the mental illnesses—schizophrenia, organic brain syndrome, dementia. Many persons suffering from these disorders are treated more frequently in the general hospital setting—particularly those suffering from organic brain syndrome and dementia. This burgeoning technological explosion is aimed at appropriate diagnosis of these disorders and charting clinical progress. New technology can help modify treatment costs downward, notwithstanding its initial costs for procurement.

Worst, if the system is set in place solely for Medicare populations, more often than not, those who could benefit to the greatest degrees from these impending breakthroughs, could we not be establishing a two-tiered system of care, where the technology is available for those privately insured, and prohibited for the Medicare beneficiary?

Other issues which arise as the result of the proposed system have been mentioned by other witnesses before this Committee, but bear repeating, since they affect the Medicare psychiatric patient in the general hospital setting in as immediate a way as they do other Medicare patients in such facilities. They have a potentially pernicious effect upon matters such as quality of care, abuses of the system, private insurance carriers (including the insured population they serve) and ultimately the Medicare beneficiary him or herself.

In order to assure a positive-cost benefit to the hospital for the Medicare beneficiary receiving treatment under a DRG system, hospitals have a number of options. Some of these may be decidedly positive, such as ensuring that unnecessary testing and services are not provided, or ensuring that, to the maximum extent possible, individuals are not kept in the hospital beyond a responsible recovery period for their specific illness (including some recognition of the severity issue). However, other methods of ensuring a "match" between Medicare patient and DRG reimbursement are potentially fraught with problems.

These include:

(1) Arbitrarily shortening hospital stays by a day or two.—This has the ironic effect, particularly in the elderly Medicare population, of likely leading to rehospitalization. Obviously, the hospital could then be reimbursed for each stay at the DRG-appropriate reimbursement level, in lieu of simply bearing the cost of an additional day or two of care beyond the DRG level, if warranted. This is clearly cost-ineffective, and also has repercussions for the beneficiary and his or her family.

(2) DRG code manipulation.—This is a variant on the above-cited problem. In this case, a patient has several serious problems. The hospital may choose to treat all of them and be reimbursed for the most expensive DRG category. Alternatively, the hospital could choose to treat one illness, discharge the patient, readmit for a second diagnosed illness, treat, etc., and thereby be able to collect payment for each of the multiple disorders from which the older patient is suffering. Such a "revolving door" approach to hospital-based treatment is not only cost inefficient, it is not good medicine.

(3) Shifting part A costs to part B.—In order to hold costs below a particular DRG reimbursement level, a hospital may require that tests and other diagnostic practices be completed on an outpatient basis, in lieu of the hospital setting. The patient is then admitted with the diagnostic charges being made to Part B, and therefore not applicable to the DRG reimbursement. This is a cost-shift within the Medicare system itself which, while not necessarily inappropriate, should be recognized for what it is: a shift, not a savings.

(4) Extending hospital stays to the extent that a patient would qualify as an "outlier," and therefore be reimbursed on a cost basis.—Short of such obviously extended stays, a hospital simply could shift costs above that provided by the DRG reimburse-

ment level to other privately insured patients—the "cost-shifting" about which this country's insurance industry is deeply concerned. The APA shares that concern, particularly since such cost-shifting could ultimately have a damaging effect upon private insurance benefits.

We believe that good utilization review—peer review of the care rendered Medicare beneficiaries—could help resolve some of these problems. However, we also believe that physicians alone do not bear the responsibility for the spiraling costs of hospital care for the Medicare patient. Hospitals and their administrators share in that responsibility. The setting of physician against hospital administration in an adversarial relationship rather than a partnership to render quality health care is a serious and real danger of this system if it is not carefully drawn. Ultimately, the group which could suffer most seriously from such a situation is the Medicare patient.

What the Department of Health and Human Services plans to set into motion is a highly complex and regulatory system: complex but not enough to account for the severity of a patient's illness; and one which, notwithstanding the Secretary's comments to the contrary, will pose a regulatory nightmare of paperwork, both at the hospital level and at the level of DHHS. This is particularly true if, as has been proposed by some who have testified before the Committee, states are allowed to experiment beyond the Medicare population. How, under such myriad of experiments, can the Federal government ensure that Medicare Part A costs are not actually increasing, other than through detailed data-gathering far in excess of what we experience today?

Both the medical profession and the government want an efficient, cost-effective system of quality health care for the nation's elderly and disabled now under or soon to be under the Medicare program. We posit that some of the problem is inherent in the Medicare system itself which continues to place its emphasis on short-term acute-care hospitalization (and I emphasize hospitalization), in lieu of lower cost outpatient alternatives to that care. If, as the Secretary's Report notes, some hospital-based activities will and should be shifted to the out-patient sector, then Medicare Part B should be looked at carefully gaps in such less costly outpatient care which leave no alternative to the medical profession but to hospitalize the patient.

Notable among these is the continued capping of benefits for the outpatient treatment of mental illness to a $250 Federal share, matched by a similar patient copayment. We know that the cost of elderly Medicare beneficiary outpatient charges (reasonable charge per enrollee) has increased more than fourfold since 1967 up from an average of $103.44 in 1967 to $416.92 in 1981). Yet there has been no recognition of the impact of such increased cost upon the treatment of mental illness. If we were to assume the same increase for the treatment of mental illness over the same 14 year period, the $250 limit is now worth ¼ of what it was in 1967, or $62.50! That is hardly cost-efficiency. Little or no effective intervention for depression or other treatable, reversible disorders of the elderly can be provided at such a level. Thje alternative is more expensive, not always necessary, hospitalization.

As we have articulated before this Committee in the past in far greater detail, it has been demonstrated widely that there is a positive cost-benefit to the provision of outpatient psychiatric care, both in terms of offset physical health care costs, and in terms of productivity. In the context of the DRG hospital cost system and its potential diversion of patients from the inpatient to the outpatient setting, its cost-enhancing and medically appropriate benefits are shown in even bolder relief.

The implications of the limited outpatient psychiatric benefit under Medicare are evident as they relate to the DRG issue. They are even more difficult when one seeks to impose a "competition" health insurance proposal on the Medicare program. At the risk of repeating testimony presented previously before this Committee, I must note that it is true that people are not clamoring for better psychiatric benefits under Medicare. In part, this is based upon misperceptions about the nature of mental illness and its treatment; in part on an individual's denial of becoming the victim of mental illness; and in part, it is based upon stigma. Since medical illness, as all other illnesses, more often than not strikes in a random fashion, many of those not suffering now from such an illness are likely not to be thinking about insuring against such an illness in the future, particularly when they deny ever falling victim to mental illness despite epidemiological evidence of the incidence of mental illness. People often do not or cannot think about what level of benefits they may require at some point in the future under a particular health plan, and, unless they are insured against such an illness, the likelihood of greater costs—both in less appropriate but insurable care, and in lost productivity—is irrefutable.

Before I close, Mr. Chairman, I would like to pose a basic question regarding the philosophy underlying the DRG-prospective payment program. I wonder how fixing costs across facilities represents any movement toward the "competition" model proposed by the Medicare voucher concept and ultimately as proposed by members of the House and Senate and the Administration as a plan to encompass all health care. We find it difficult to reconcile these two proposals, and thus difficult to reconcile the prospective payment system with other proposed changes in the Medicare, Medicaid and private health insurance systems not pending before this Committee.

In sum, the APA urges extreme caution: caution in applying the DRG system to inpatient psychiatric care in the general hospital setting; caution with respect to the damages to biomedical research and technology development; caution with respect to the potential for abuse of the system, whether internally or as shifted to the private insurance sector; caution with respect to the shift to greater reliance on a severely restrictive outpatient psychiatry benefit; and caution with respect to the potential regulatory nightmare the proposal as now developed could create. The APA believes that there is a need to rein in runaway hospital costs under Medicare, but recommends that appropriate testing and validation of several methods be completed before launching a nationwide uniform program—methods that look at both cost efficiency and its impact on the quality of care.

The APA looks forward to working with the Committee in developing appropriate responses to these critical issues. We appreciate the opportunity to have appeared before the Committee on this issue of such critical importance to medical care for the Medicare population.

BRIEF COMMUNICATIONS

Clinical and Cost Benefits of Liaison Psychiatry

BY STEPHAN J. LEVITAN, M.D.; AND DONALD S. KORNFELD, M.D.

A liaison psychiatrist participated in the postoperative care of a group of elderly patients who underwent surgery for fractured femurs. Clinical outcomes for this group were compared with a control group of patients who were not treated by a liaison psychiatrist. Length of stay for the treatment group was 12 days shorter than for the control group, and twice as many patients in the treatment group returned home rather than being discharged to a nursing home or other health-related institution; therefore, a substantial reduction in the cost of their medical care was effected. The authors suggest that psychiatric liaison services should be viewed as a potential cost containment mechanism for general medical care.

The field of liaison psychiatry has undergone great growth in the past decade. Reifler and Eaton (1) report that no less than 50 adult consultation liaison programs requested federal grant support for fiscal year 1977. While it is generally assumed that liaison services contribute significantly to improved patient care, few studies have been conducted to confirm this assumption. A review of the evaluation literature by Cohen-Cole (2) revealed only two studies of patient outcome. Dubovsky and associates (3) found a decrease in mortality on a coronary care unit where a liaison psychiatrist met regularly with the nursing staff. Adsett and Rudnick (4) found a decrease in the number of psychiatric hospitalizations and emergencies in a community-based family medicine practice after the addition of a liaison psychiatrist. The impact of liaison psychiatry on the cost of medical care has not been studied; however, one study of short-term outpatient mental health interventions found reductions in the utilization of medical care services as a result of these interventions (5). The cost of these programs appeared to be at least partially offset by the savings from the reduced medical care utilization.

Our liaison relationship with the orthopedic surgery service at Presbyterian Hospital afforded an excellent opportunity to study the clinical and cost benefits of liaison psychiatry. Elderly patients undergoing emergency surgery for fractured femurs are at high risk for postoperative psychopathology. Thomas and Stevens (6) studied the social effects of fractures of the neck of the femur in older patients and noted that such fractures frequently resulted in prolonged increased dependence.

Our study was designed to test the hypothesis that a liaison psychiatrist could improve clinical outcome and reduce the cost of medical care by favorably influencing the postoperative course of patients aged 65 or over undergoing surgery for fractured femurs. We predicted a reduction in the length of hospital stay and an increase in the number of patients who could return home after discharge.

METHOD

A liaison psychiatrist (S.J.L.), working part-time (10 hours per week), followed all patients aged 65 and over admitted to a female orthopedic surgical unit for emergency surgical repair of a fractured femur during a 6-month period (April–September 1977). Patients were seen within 72 hours of admission and followed

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and treated by the psychiatrist until discharge. The liaison psychiatrist, as a member of the treatment team, worked closely with the house staff, the nursing staff, the social service department of the hospital, the attending staff, the physiotherapy department, aides, volunteers, and family and friends.

Clinical outcomes were defined as 1) length of hospital stay, and 2) discharge disposition (the number of patients who were "discharged home" as opposed to the number of patients who were discharged to a nursing home or other health-related facility). Outcome data were obtained from the hospital record of each patient.

We will refer to the 24 patients followed by one of us (S.J.L.) as the liaison group and the 6-month intervention period as the experimental time period. The clinical outcomes in the liaison group were compared with the clinical outcomes in 26 patients who were not followed by a liaison psychiatrist but had been admitted to the same orthopedic unit during the same calendar months 1 year earlier for the emergency surgical repair of a fractured femur. We will refer to these patients as the control group and to their 6 months in the hospital as the control time period. Comparison of liaison and control groups revealed no significant differences in age distribution (t test) or preoperative levels of functioning (Mann-Whitney U test). All patients were ward patients. The same surgical technique was used for the repair of the fractured femurs of patients in both the liaison and control groups. To the best of our knowledge, with the exception of normal staff turnover, conditions on the unit were the same during the experimental and the control time periods.

To control for the possibility that any observed significant decrease in the lengths of hospital stay would be due to some factor other than the interventions of the liaison psychiatrist, we needed additional comparisons. If some factor was causing a decrease in hospital stays in general, one would expect a decline in the average length of stay for all patients admitted to the surgical unit. Therefore, the average lengths of stay for all patients receiving knee and hip surgery (excluding fractured femurs) during the experimental and control time periods were compared. The average lengths of stay for all patients receiving total prosthetic joint replacement (total knee and total hip) during the experimental and control time periods were also compared.

We used *DSM-III* criteria to formulate psychiatric diagnoses for patients in the liaison group. The following are brief clinical examples of psychopathological situations and typical interventions by the liaison psychiatrist.

Postoperative Delirium

An 87-year-old widow, living alone with some assistance from a neighbor, fell on a scatter rug. After surgery she was disoriented and delusional and had visual hallucinations. The liaison psychiatrist started her on thioridazine and her symptoms improved; he helped the patient and her family to understand that she was not senile (as they had feared). The family wondered if they should give up the patient's apartment, but they were reassured by the psychiatrist that her mental status would not deteriorate again. She was sent home after discharge, and a home health care attendant was provided.

Iatrogenic Organic Brain Syndrome

A 78-year-old retired actress, who lived with her partially blind sister and employed a part-time housekeeper, slipped on her newly waxed kitchen floor. After surgery she was mentally dull, lethargic, and somewhat ataxic, and her ambulation progressed very slowly. Postoperative orders for 30 mg of flurazepam at bedtime and 5 mg t.i.d. of diazepam had been renewed continually. After both drugs were discontinued on the recommendation of the liaison psychiatrist, her symptoms improved. The patient was discharged home to the care of her housekeeper and arrangements were made for a visiting nurse.

Postoperative Anxiety

An 80-year-old retired woman, living with her husband, fell while getting out of her bathtub. Postoperative attempts at ambulation were unsuccessful because the patient was extremely afraid of falling. She cried, required continuous reassurance, and refused to relinquish her special duty nurse. The liaison psychiatrist prescribed diazepam with the strong suggestion that it would help her to overcome her fear of walking. Gradually her fear abated and she was able to walk. Her daughter agreed to live in the patient's home temporarily, after which a housekeeper would assist the patient.

Family Counseling

An 85-year-old widow, living alone, slipped while getting out of the tub. After surgery she was frequently confused and disoriented in the mornings. Her son feared that she had become senile and prepared to give up her apartment and request permanent placement in an old age home. The liaison psychiatrist reassured him that the elderly often react to surgery in this manner and that it was usually temporary. The patient had been receiving chlordiazepoxide for sleep regularly since surgery; soon after it was discontinued and thioridazine substituted on the recommendation of the liaison psychiatrist, the patient's disorientation and confusion abated. The son agreed to the original plans to discharge the patient to her home.

Behavioral Management Problem

An 83-year-old widow, living with a friend, fell one night while wandering out of bed in a confused and agitated state. After surgery the patient became so noisy and agitated every night that she had to be wheeled into the hallway so that other patients could sleep. The staff and her friend became discouraged. A conference was held to formulate a vigorous treatment plan: 24-hour special duty nursing care was ordered, and the patient began taking haloperidol. The social service department of the hospital contacted the patient's sister, who agreed to visit regularly, and suggested that the friend bring in familiar objects from home. Soon, although still confused during the day, the patient was quiet and able to sleep at night. She was discharged home and continued to take maintenance doses of haloperidol.

Iatrogenic Depressive Reaction

An 82-year-old widow, living alone with the help of a part-time housekeeper, fell at home. After surgery the patient became apathetic and lethargic and experienced some loss of appetite. She admitted to feeling depressed and apprehensive. Previously unknown details of her history included successful treatment with imipramine within the past year for atypical facial pain; she had been receiving maintenance doses of imipramine until the time of admission. After surgery she became apprehensive that her maintenance imipramine had not been reordered, but she did not communicate her fears to the staff. Although aware that her mood was becoming more and more depressed, she did not associate this with the discontinuation of the imipramine. The patient was relieved when we discovered the oversight and restarted her imipramine immediately. Before long her mood improved, her appetite returned, and she looked forward to going home.

Liaison with Nursing and Physiotherapy Staff

A 73-year-old woman, living with her sister, slipped in the street. After surgery she was afraid to walk. Her ambulation proceeded so slowly that her nurses began to blame the patient and the physiotherapists avoided her. A conference was held at which the staff ventilated these feelings and formulated a treatment plan; after this the staff became enthusiastic about helping the patient. Staff members began to spend more time with the patient and learned much about her early life. The social worker contacted the members of the church choir in which the patient had sung and some began to visit her regularly. The program was a success, and the patient began to walk again. She was able to return home to her sister's care, which was supplemented by the visiting nurse service.

Depression Masquerading as Organic Brain Syndrome (Pseudodementia)

An 81-year-old widow, living with her daughter for the past 4 months, fell while visiting her own apartment. After surgery she appeared confused, distant, and apathetic and experienced a memory deficit for recent events. Her daughter and the staff were convinced she was becoming senile. The daughter considered giving up the patient's apartment and looking for an institutional placement. Closer scrutiny of the case revealed that the patient's husband had died 4 months previously. The liaison psychiatrist considered a diagnosis of retarded depression. After he met with the patient several times, she was able to cry and express her grief at the death of her husband; she also expressed guilt for having become a burden to her daughter. The staff was encouraged to offer attention and support. Efforts were made to have the grandchildren visit. The patient started taking amitriptyline, after which her thinking accelerated gradually and her memory for recent events improved. She was discharged to her daughter's home, and her return to her own home in the near future with help from a home health aid was planned.

Exacerbation of Schizophrenia

A 77-year-old woman was admitted to the neurology service for evaluation of confusion and agitation. Although restrained in a chair because of her agitated state, she fell to the floor. She was transferred to the orthopedic service. After surgery she experienced hallucinations and delusions. An interview with the family revealed a history consistent with paranoid schizophrenia. Haloperidol was effective in relieving her symptoms, and the patient was discharged to a rehabilitation facility.

Liaison with Social Service

A 77-year-old widow, living alone, fell at home. Because her medical history included a diagnosis of chronic schizophrenia, her application to a nursing home was rejected. The social service department conveyed the psychiatrist's opinion to the nursing home staff that the patient's schizophrenia was well controlled with haloperidol and that she would not be a management problem. As a result the application was accepted.

RESULTS

In the liaison group 17 patients demonstrated psychopathology, and 9 received more than one psychiatric diagnosis: organic brain syndrome, $N=10$; adjustment disorder with depressed mood, $N=8$; adjustment disorder with anxious mood, $N=7$; major depressive episode, $N=1$; and schizophrenia, $N=1$. Because there was one death in the liaison group and three in the control group, for statistical analysis the sample size for each group was 23.

The lengths of hospital stay were compared by computing the difference between group medians. The median was 30 days for the liaison group and 42 days for the control group. The difference between the groups was significant (Mann-Whitney $U=185$, $p<.05$).

In the liaison group 16 patients went home and 7 went to a nursing home or other health-related institution. In the control group 8 patients went home and 15 went to a nursing home or other health-related institution. The difference between the two groups was significant ($\chi^2=4.27$, $p<.05$).

We found no significant difference when we compared the lengths of stay for all patients receiving knee and hip surgery (excluding fractured femurs), even when an extremely liberal $\alpha=.1$ was used (Mann-Whitney $U=697$, n.s.): during the control time period there were 33 patients who had a median stay of 17 days; during the experimental time period there were 44 patients who had a median stay of 19.5 days. The slight difference that existed was in the direction of longer hospital stays during the experimental time period.

We also found no significant difference when we compared the lengths of stay for all patients receiving total prosthetic joint replacement (Mann-Whitney $U=119$, n.s.): during the control time period there were 18 patients who had a median stay of 21 days; during the experimental time period there were 19 patients who had a median stay of 25 days. The difference that existed was in the direction of longer hospital stays during the experimental time period.

The greater number of deaths in the control group, three as opposed to one in the liaison group, was not statistically significant.

DISCUSSION

As predicted, we found significant differences in both measures of clinical outcome between the liaison and control groups. The median length of hospital stay was 12 days less for the liaison group than for the control group, and twice as many liaison group patients were discharged home. Additional comparisons for control purposes demonstrated no general tendency toward shorter hospital stays during the experimental time period. In fact, if anything, these comparisons suggest a general trend toward longer hospital stays during this time period. It is, therefore, unlikely that some unrelated variable produced the reduced length of stay in the liaison group. We conclude with reasonable certainty that the observed decrease in length of hospital stays was attributable to the interventions of the liaison psychiatrist. Of course, shorter hospital stays in the liaison group may be in part a function of the enhanced ability of these patients to return home. Patients who are unable to return home may stay longer because they have to wait for a bed to become available in another institution.

The current average daily rate for hospitalization in the New York metropolitan area is greater than $200 a day. At $200 a day, an average reduction of 12 days per patient, for 23 patients, would amount to a savings of $55,200 over a 6-month period, or $110,400 per year. In the New York metropolitan area, the average costs for institutional care of the elderly vary from $300 to $500 a week, and the cost of home care averages no more than $200 a week. Therefore, home care offers a minimum savings of $100 a week. Eight more patients in the liaison group than in the control group were able to return home; assuming that all patients in our sample lived 1 year after discharge, a savings of $41,600 would accrue. If the study had been conducted for a full year, thus doubling sample size, the savings would have been $83,200. Hence, we estimate that the work of one liaison psychiatrist resulted in a projected savings of $193,600 over the course of 1 year. At the time of the study the psychiatrist's annual part-time salary was $10,000.

Psychiatric research in the general hospital presents well-known problems for experimental design. Methodologic considerations for defining independent variables, assigning controls, and measuring changes in dependent variables are difficult when studying patients who have complex medical or surgical illnesses. Therefore, a note of caution seems prudent. Although the observed differences in clinical outcomes of our two patient groups seem to be the result of the interventions of the liaison psychiatrist, it is possible that other variables may have contributed to these results. Additional studies of this kind are needed to confirm these findings.

Our results support the hypothesis that a liaison psychiatrist can improve clinical outcome and reduce the costs of medical care by favorably influencing the postoperative course of patients aged 65 or over undergoing surgery for fractured femurs. We hope that this study will serve as a stimulus for further research to demonstrate the clinical and cost benefits of liaison psychiatry in other settings.

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The Effects of Psychological Intervention on Recovery From Surgery and Heart Attacks: An Analysis of the Literature

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Abstract: A quantitative review of 34 controlled studies demonstrates that, on the average, surgical or coronary patients who are provided information or emotional support to help them master the medical crisis do better than patients who receive only ordinary care. A review of 13 studies that used hospital days post-surgery or post-heart attack as outcome indicators showed that on the average psychological intervention reduced hospitalization approximately two days below the control group's average of 9.92 days. Most of the interventions were modest and, in most studies, were not matched in any way to the needs of particular patients or their coping styles. Beyond the intrinsic value of offering humane and considerate care, the evidence is that psychological care can be cost-effective. (*Am J Public Health* 1982; 72:141–151.)

Introduction

Most studies of the effects of psychotherapy on utilization of medical services have considered ambulatory patients in office practices and health maintenance organizations (HMOs). However, there is also evidence that the patient's emotional status may influence the time it takes to recover from acute episodes of severe illness or from surgery. Such findings have obvious relevance for health care planning and financing.

The literature documents many ways in which psychological factors can influence health and the use of medical services, and three of these have particular relevance for patients in medical crisis: 1) emotional factors may influence the course of existing disease and recovery from medical crisis;[1-5] 2) the patient's emotional response to his/her disease may influence prescribing by the physician;[6,7] and 3) the patient's response to symptoms and to medical advice can influence the patient's subsequent management of his/her own disease.[8-12]

Impact of Emotions on Disease and Recovery

Kimball found that, of 54 adult patients admitted for open heart surgery, mortality was highest among patients who had been identified as "depressed" prior to surgery, although these patients were not at more risk on the basis of age, rating of cardiac functioning, or duration of illness.[13] Sime studied 57 women admitted for abdominal surgery and found that high levels of preoperative fear were associated with slower recovery, greater use of analgesics, and more negative emotions.[14]

Low morale was a significant predictor of death in the study by Garrity and Klein that assessed 48 patients for anxiety, hostility, and depression as compared with calmness and cheerfulness five days following admission to intensive coronary care. Of the 12 patients who died within six months of discharge, 10 had been characterized as suffering from unresolved emotional distress, and previous physical status did not explain the excess death rate among the depressed patients.[15]

Zheutlin and Goldstein studied 38 patients suffering major cardiac insult and reported that the combination of one Minnesota Multiphasic Personality Inventory (MMPI) scale and a cardiac status index predicted more than 70 per cent of the variance in patient recovery as assessed in a cardiac work evaluation unit.[16] Bruhn, Chandler, and Wolf found that 17 patients with myocardial infarctions who subsequently died had significantly higher MMPI depression scores than did survivors.[17]

Physician's Decision about Treatment

Kinsman, Dahlem, *et al.* have studied the patient's style of emotional response to asthma as it influences medical decisions about treatment.[6,7] Patients who scored high on a scale of "panic-fear symptomatology" tended to be kept in the hospital longer than low-scoring patients although objective measures of airway limitation did not indicate greater physiologic distress. These patients were often sent home on higher dosages of medication than were patients who had scored lower on the "panic-fear" scale. The differences in

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Editor's Note: See also related editorial, p 127 this issue.

medication were not explainable by objectively determined physical status.[6,18] High panic-fear patients may intimidate doctors into allowing unnecessary hospitalizations. Patients extremely low on panic-fear may, in denying symptoms, seek medical care only when in acute distress and at a point when hospitalization is required.[7,19]

Patient's Response to Medical Advice

Clinicians believe that a hopeful and cooperative patient tends to have a smoother and swifter recovery than a depressed and uncooperative patient. Yet the hospital experience, as it is currently structured, may interfere actively with the patient's willingness and ability to cooperate effectively to achieve recovery. Not told what to expect next, and admonished to rely on the experts, patients and their families are disadvantaged when they strive to cooperate. Some benefits from psychologically-informed intervention in the studies to be reviewed may reflect correction of defects in the social system in which recovery and recuperation are expected to take place. Preparatory education and restructuring delivery experiences enhance the ability of obstetrical patients to cooperate with their physicians.[20,21] The literature we analyze here suggests similar benefits from emotional and social support for patients recovering from medical and surgical crisis.

Materials and Methods

Meta-Analysis of Psychological Intervention

With the help of a Medlars search (1955–1978) and subsequent pursuit of key references through the Citation Index, we located 34 controlled, experimental studies in the published and unpublished literature that tested the effects of providing psychological support as an adjunct to medically required care for patients facing surgery or recovering from heart attack.[3,4,23–55]

The term "psychological intervention" covers a wide range of activities performed by psychiatrists, psychologists, surgeons, anesthesiologists, nurses, and others intended to provide information or emotional support to patients suffering disabling illness or facing surgery. These activities range from special programs to quite simple and inexpensive modifications of, or additions to, required medical procedures.

For example, in a study of the influence of psychological preparation for surgery, the evening before surgery 25 male patients discussed their concerns and fears in a small group led by a nurse. They were told what to expect and how to aid in their own recuperation. This group was contrasted with a randomly selected control group of 25 male patients who underwent similar surgical procedures with only the routine care. The experimental patients slept better, experienced less anxiety the morning of surgery, and recalled more details but fewer fearful or unpleasant images from the day of surgery. They suffered less postoperative urinary retention, required less anesthesia and pain medication, returned more rapidly to oral intake, and were discharged sooner than the control patients.[4]

In each of the studies reviewed, the recovery of patients who received information or emotional support in preparation for surgery, or during recovery from surgery or from heart attack, was compared with that of a control group not provided the special intervention. The Appendix Table summarizes the circumstances and findings of each study with the following information:

- patients sampled
- medical or surgical problem
- nature of intervention and provider
- sampling method used in the study
- size of experimental and control groups
- description of the outcome indicators
- effect size (ES) of the outcome indicators

The effect size (ES) of the outcome indicators is a standardized measure, the average difference between the treatment and control group on the outcome variable divided by the standard deviation of the control group. The ES can be interpreted in terms of the improvement or loss that the average member of the control group would experience if given the experimental treatment. A positive ES in the Appendix tables signifies the difference favors the group receiving the psychological intervention.[22]

Results

The ESs for all 210 outcome indicators in the 34 studies average +.49; the intervention groups do better than the control groups by about one-half standard deviation. These findings are consistent across studies; only 31 (15 per cent) of the 210 outcome comparisons were negative and 8 of the negative ESs are contributed by one study.[35]

Table 1 is based only on the 180 ESs derived from well-controlled studies that reported standard deviations. We exclude measures from studies that did not either randomly assign or carefully match experimental and control patients. We also exclude measures from studies that provided neither standard deviations nor statistics that allowed for their estimation.

Table 1 analyzes the ESs within 10 outcome categories segregating psychological self-reported "pain" variables and other-rated, physiological or "medical" variables. The ESs based on external indicators are, for the most part, larger than those for the self-ratings and average +.45 compared with +.35. The highest ESs are for cooperation with treatment, speed of recovery, and fewer post-hospital complications (events). One can conclude that in general cooperation with treatment influences both speed and uneventfulness of recovery, an observation also made by Ley in his review of studies of the effects of different types of pre-operative communications on various outcome variables.[36]

The "psychological interventions" described in the Appendix Table can be categorized in terms of their intended mode of action. Some studies tested educational methods and approaches designed to provide patients with information about their conditions and what to expect. Other studies tested various psychotherapeutic approaches intended to provide reassurance, to soften irrational beliefs, or in general

TABLE 1—Average Effect Sizes within 10 Outcome Categories

	Mean	S.D.	N*
Self Ratings			
1. Pre-op. anx., pain.	+.32	.73	6
2. Post-op. anx., pain.	+.38	.59	32
$\overline{ES}$ =	+.35		
Other Rating and External Indicators			
3. Cooperation with treatment	+.60	.40	11
4. Pre- & Post-op. pain-distress (other rated)	+.44	.46	43
5. Post-op. physiological indicators	+.28	.50	25
6. Post-op. narcotics, hypnotics, etc.	+.17	.42	13
7. Speed recovery	+.80	.50	17
8. Post-op. complications	+.38	.47	13
9. Post-hosp. course (events)	+.60	.34	10
10. Days in hospital	+.25	.28	10
$\overline{ES}$ =	+.45		N = 180
Grand $\overline{ES}$ =	+.43		

* Most studies included more than one outcome indicator category

to offer emotional support and relieve anxiety. Some studies offered interventions of both types. In the Appendix Table, reading down the third column "Nature of Experimental Group Intervention," one observes that psychotherapeutic approaches (ES +.41; s_{ES} .65; N 87) seem rather more effective than educational approaches (ES +.30; s_{ES} .51; N 56) which are also effective. A combination of both approaches seems clearly superior to either alone (ES +.65; s_{ES} .45; N 40).

A subset of the outcome indicators is particularly important for its cost implications. Thirteen studies reported 14 comparisons of the number of days hospitalized for the intervention and control groups. Ten of these studies provide adequate data for meta-analysis. The average difference in days of hospitalization for the 10 comparisons weighted equally is about two days in favor of the intervention group.[*] Table 2 summarizes these findings. It can be argued that studies with larger numbers of patients should be given more weight in deriving a composite. Reasoning also that a mean should be weighted inversely to its variance error, weighting each by the sample size would be appropriate. The average difference weighted for sample size and size of standard error equals 2.37 days, slightly higher than the unweighted average. Hence a reasonable estimate of the true difference between intervention and control groups favors the intervention group by more than two days.

Is this difference statistically reliable? The estimate of about two days shorter hospitalization for patients having psychological intervention is based on data from approximately 2,000 intervention and control patients across the four comparisons. Seven studies gave the standard deviation of hospital stay. The average standard deviation is 4.75 days and t = 7.32, significant at any reasonable level. If we analyze the findings using the study as the unit of analysis a significant t of 3.42 results.

We attempted to include the entire population of interest, i.e., all published and unpublished controlled experimental studies of the effects of psychological intervention in medical crisis.[**] One might suspect that unpublished studies would be more likely to contain negative results than would published studies. Smith attempted to study whether published studies are biased in favor of positive findings. She found that the average ES obtained by meta-analysis of data from published articles is about one-third larger than the ES from theses and dissertations that used comparable outcome indicators and subjects.[58] Two of the studies included in the Appendix Table are unpublished.[41,42] The effect sizes for one are slightly negative, for the other quite positive.

Discussion

It is important to recognize that these favorable effects prevail even though the interventions were mostly modest and not tailored to the needs of any individual patient. Since patients differ in the way they cope with emotional and physical threat, they might be expected to benefit most from interventions designed to complement their particular coping styles. The apparent superiority of providing both educational and emotional support may simply reflect increased chances of meeting the needs of more patients when two different types of intervention are offered.

A few studies offer evidence that the benefits of intervention are enhanced when the type of support provided is matched to the individual coping style of the pa-

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[*] One study not included in the analysis reported simply "shorter stay" for patients given information compared with control patients.[57]

[**] After we had completed our analysis, another study was published finding a 12-day shorter hospital stay for a treatment group compared with a control group of elderly patients operated on for repair of fractured femurs. Twice as many patients in the treatment group returned home rather than to another institution.[59]

TABLE 2—Duration of Hospitalization for Intervention and Control Groups for Fourteen Studies

Author(s) Medical Problem	Intervention Group		Control Group			
	Average days hospitalized	*N*	Average days hospitalized	*N*	Difference (Δ)	Standard Error$_\Delta$*
Archuleta, Plummer & Hopkins[1] (1977) Major surgery	7.49	248	6.90	267	−.59	.43
Fortin & Kirouac[36] (1976) Major surgery	6.44	37	6.35	32	−.09	.50
Langer, Janis & Wolfer[38] (1975) Major surgery	5.64	15	7.60	15	1.96	.37
Gruen[3] (1975) Myocardial infarction	22.50	35	24.90	35	2.40	1.43
Surman, *et al*[38] (1974) Cardiac surgery	13.40	20	17.00	20	3.60	**
Schmitt and Wooldridge[4] (1973) Elective surgery	9.70	25	11.80	25	2.10	1.07
Lindeman and Stetzer[39] (1973) Elective Surgery						
Adults	6.70	90	6.65	86	−.05	.45
Children	2.11	19	3.00	11	.89	.69
Lindeman and Van Aernam[40] (1971) Major surgery	6.53	126	8.44	135	1.91	.62
DeLong[42] (1971) Abdominal Surgery	6.17	31	7.18	33	1.01	.50
Andrew[44] (1970) Hernia surgery	6.91	22	6.78	18	.13	.95
Healy[45] (1968) Abdominal surgery	—	181	—	140	5.00	**
Egbert *et al.*[46] (1964) Abdominal Surgery	—	51	—	46	2.70	1.06
Kolouch[61,62] (1962, '64) Elective Surgery	6.86	197	12.40	"many thousands"	5.54	.10

* Standard Error of the difference between the means equals $\hat{S}_p \times \sqrt{\frac{1}{n_i} + \frac{1}{n_c}}$ where S_p is the pooled standard deviation.

** Data insufficient to calculate Standard Error.

tient.[14,23,40,42,59] A patient who copes reasonably well with the help of denial may find detailed explanations about impending surgery or cardiac damage burdensome while another patient who copes with stress by seeking information and mastery could be reassured and helped by the same explanation.[43]

Surgical intervention or treatment on a coronary care unit may be viewed as a crisis as Whitehead defined it, "a dangerous opportunity." Analogous to the risks and benefits of medical and surgical interventions, the hospital experience itself may also be a dangerous opportunity for the patient's survival and subsequent social and emotional adjustment. The patient regaining his/her balance following a medical crisis can change direction and assume new and potentially better patterns of adaptation.[44-45] On the other hand, if the dangerous opportunity is not seized, needless incapacity may result. Survivors of heart attack range from the cardiac cripple to those whose emotional and social lives have been turned for the better.

The elaborate services provided in the surgical recovery room or the coronary care unit leave little to chance. They contrast markedly with the minimal attention systematically provided to educate patient and family for recuperation following hospitalization. In an action-oriented society, reports of the considerable effectiveness of modest interventions may command less attention than reports of the modest effects of more flamboyant interventions.

It is often argued that the medical care system cannot afford to take on the emotional status of the patient as its responsibility. Time is short and costs are high. However, it may be that medicine cannot afford to ignore the patient's emotional status assuming that it will take care of itself. Anxiety and depression do not go away by being ignored. The psychological and physiological expressions of emotional upheaval may be themselves disastrous for the delicately balanced patient or may lead to behavior that needlessly impedes recovery when surgery or medical treatment was otherwise successful.

Usually advances in medical knowledge call for large investments in training, personnel, and equipment if patients are to benefit. Thus, a measure that promises to benefit patients and to save money at the same time is newsworthy.

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APPENDIX

APPENDIX TABLE—The Effects of Psychologically-Informed Intervention on Recovery from Medical Crisis[a]

Study: Authors and Date	Patients Sampled: Medical Problem or Procedure	Nature of Experimental Group Intervention; Duration; Provider	Sampling Method: n_1 = size of experimental group[b] n_2 = size of control group[b]	Outcome Indicators	Outcome Effect Size: (ES) (+ favors Experimental Group)
Flagherty & Fitzpatrick[23] (1976)	Adults: Major surgery	Relaxation technique at 1st attempt to get out of bed, post-op. nurse	Random: n_1 = 21 n_2 = 21	a. Post-op. Demerol	+ .76
				b. Incision Pain	
				1. Intensity	+ .95
				2. Distress	+2.70
				c. Change in blood pressure	
				1. Systolic	+ .03
				2. Diastolic	− .10
				d. Change in pulse rate	+ .27
				e. Change in respiration	+ .80
Finesilver[24] (1978)	Adults: Cardiac catheterization and coronary cineangiography	Specific information and emotional support, 2 sessions: 1. At admission 2. Day before surgery; by investigator	Random: n_1 = 20 n_2 = 20	a. Medication administered during surgery[c]	+1.22
				b. Mood adjective checklist	
				1. Well-being	+ .04
				2. Happiness	+ .14
				3. Fear	+ .11
				4. Helplessness	+ .19
				5. Anger	+ .16
				c. Distress during hospitalization (nurse's rating)	+ .74
				d. Cooperation during catheterization (nurse's rating)	+ .17
				e. Post-catheterization rating by patients of how "upset" they were by procedure	+ .24
Archuleta, Plummer and Hopkins[1] (1977)	Adults: Major surgery	Preoperative teaching by nurse plus 5 min. reinforcement.	Random: n_1 = 248 n_2 = 267 In 11 hospitals	a. Days hospitalized	− .15
				b. Analgesics used	− .09
				c. Forced vital capacity	− .10
				d. Maximal midexpiratory flow	+ .02
				e. Forced expiration volume at 1 second	− .05
Felton, Huss, Payne et al.[25] (1976)	Adults: 1st time major surgery under general anesthesia	1. Preoperative information by nurse, photographs and films, average time 88 min.	Random: n_1 = 25 n_2 = 25	a. Days hospitalized[d]	—
				b. Ventilatory function	
				1. 24 hrs. post-op	+ .05
				2. 48 hrs. post-op	− .38
				3. 72 hrs. post-op.	− .25

APPENDIX TABLE—Continued

Study: Authors and Date	Patients Sampled: Medical Problem or Procedure	Nature of Experimental Group Intervention; Duration; Provider	Sampling Method: n_1 = size of experimental group[b] n_2 = size of control group[b]	Outcome Indicators	Outcome Effect Size: (ES) (+ favors Experimental Group)
				c. Heart or circulatory complications[c]	+ .60
				d. Multiple affect adjective checklist (anxiety)	+ .28
				e. Personal orientation inventory	
				1. Inner-directedness	+1.53
				2. Self-regard	+ .87
				3. Acceptance of aggression	+ .33
		2. Therapeutic communication approach by nurse, average time 62.5 min.	Random: n_1 = 12 n_2 = 25	a. Days hospitalized	0.00
				b. Ventilatory function	
				1. 24 hrs. post-op.	0.00
				2. 48 hrs. post-op.	− 0.48
				3. 72 hrs. post-op.	− .71
				c. Heart or circulatory complications	+1.45
				d. Multiple affect adjective checklist (anxiety)	+ .17
				e. Personal Orientation Inventory	
				1. Inner-directedness	0.00
				2. Self-regard	− .53
				3. Acceptance of aggression	− .85
Fortin and Kirouac[26] (1976)	Adults: Major surgery	Preoperative education and training by nurses 1 session per week starting 15–20 days before hospitalization	Random: n_1 = 37 n_2 = 32	a. Inpatient ambulatory activity	+ .43
				b. Activities of daily living	
				1. 10 days post-op.	+ .83
				2. 33 days post-op.	+ .79
				c. Days before return to work or usual level of activity	+ .42
				d. Analgesics	+ .63
				e. Absence of pain and nausea at discharge	+ .69
				f. Satisfaction with hospitalization[d]	—
				g. Days hospitalized	+ .05
				h. Days lost from work in 33 post-op. days[e] Exper. = 23.8 days Control = 26.0 days	—
				i. Readmission or death	0.00
Auerbach, Kendall, Cuttler, et al.[27] (1976)	Adults: Dental surgery	Audio-tape of specific information about surgery by dental student	Random: n_1 = 29 n_2 = 19	a. State anxiety	
				1. Immediately after intervention	− .38
				2. Immediately after surgery	+ .22
Gruen[3] (1975)	Adults: Myocardial Infarction	Eclectic Verbal: Psychiatrist, ½ hr. a day for 5–6 days "to awaken hope"	Random: n_1 = 35 n_2 = 35	a. Days hospitalized	+ .23
				b. Days in intensive care	+ .49
				c. Days on monitor	+ .36
				d. Number of patients with congestive heart failure	+ .40
				e. Congestive heart failure, days per patient	− .02
				f. Number of patients with arrythmias	+ .50
				1. Ventricular	+ .50
				2. Supraventricular	+ .85
				g. Nurse ratings	
				1. Chest pain	+ .09
				2. Other pain	− .41
				3. Depression	+ .25
				4. Anxiety	− .16
				5. Refusals of treatment	− .28
				6. Weakness, exhaustion	+ .48
				h. Physician ratings	
				1. Depression	+ .33
				2. Anxiety	− .05
				3. TMAS Bendig Score	+ .06
				4. ST Anxiety Inventory	+ .14
				5. MAACL Anxiety	+ .14
				i. Nowlis Adjective Checklist	
				1. Anxiety	+ .09

APPENDIX TABLE—Continued

Study: Authors and Date	Patients Sampled: Medical Problem or Procedure	Nature of Experimental Group Intervention; Duration; Provider	Sampling Method: n_1 = size of experimental group[b] n_2 = size of control group[b]	Outcome Indicators	Outcome Effect Size: (ES) (+ favors Experimental Group)
				2. Surgency	+ .65
				3. Elation	+ .32
				4. Affection	+ .54
				5. Sadness	+ .32
				6. Vigor	+ .30
				j. Four-month follow-up	
				1. Anxiety	+ .71
				2. Retarded activity	+ .42
Langer, Janis and Wolfer[28] (1975)	Adults: Major Surgery	Combination RET (Ellis) and learning theory (Kanfer), psychologist, 20 minutes	Random: n_1 = 15 n_2 = 15	a. Nurses' ratings	
				1. Anxiety	+ .51
				2. Ability to cope	+1.15
				b. Per cent of subjects requiring[c]	
				1. Sedatives	+ .90
				2. Pain relievers	+1.15
				c. Days hospitalized[e]	—
				Exper. = 5.64 days	
				Control = 7.60 days	
	Adults: Major Surgery	Preparatory information only, psychologist 20 minutes	Random: n_1 = 15 n_2 = 15	a. Nurses' ratings	
				1. Anxiety	− .62
				2. Ability to cope	− .30
				b. Per cent of subjects requiring[c]	
				1. Sedatives	+ .63
				2. Pain relievers	+ .42
				c. Days hospitalized[e]	—
				Exper. = 7.2 days	
				Control = 7.6 days	
Melamed and Siegel[29] (1975)	Children: Tonsils, hernia, urinary surgery	Film: "Ethan Has an Operation", 12 min.; Actors	Matched: n_1 = 30 n_2 = 30	a. Measures taken post-intervention, but immediately pre-op.	
				1. Anxiety scale of Personality Inventory for Children	+ .67
				2. Behavior Problems Checklist (not taken)	—
				3. Palmar Sweat Index	+ .75
				4. Hospital Fears Rating Scale	+ .75
				5. Observer Rating of Anxiety	+ .60
				Observer Rating of Anxiety	0.00
				Observer Rating of Anxiety	0.00
				b. Measures taken 20 days Post-op.	
				1. Anxiety Scale of Personality Inventory for Children	+ .50
				2. Behavior Problems Checklist	+ .60
				3. Palmar Sweat Index	+ .60
				4. Hospital Fears Rating Scale	+ .75
				5. Observer Rating of Anxiety	+ .60
				Observer Rating of Anxiety	0.00
				Observer Rating of Anxiety	0.00
Wolfer and Visintainer[f,30] (1975); Visintainer and Wolfer[31] (1975)	Children: Elective surgery	"Psychologic preparation and support" by same nurse 1 hour across 6 points in time during hospitalization	Random: n_1 = 45 n_2 = 35	a. During blood test	
				1. Anxiety	+ .70
				2. Cooperation	+ .60
				b. During pre-op. medication	
				1. Anxiety	+1.32
				2. Cooperation	+1.20
				3. Pulse rate	+1.07
				c. During transport to O.R.	
				1. Anxiety	+ .52
				2. Cooperation	+ .51
				d. While in O.R.	
				1. Anxiety	+ .58
				2. Cooperation	+ .63
				e. Ease of fluid intake	+ .43
				f. Minutes to first voiding	+ .85
				g. Recovery room medication	+ .65
				h. Post-hospital adjustment	+ .90
Johnson and	Children:	Puppet therapy 1 time pre-	Random:	a. Palmar Sweat Index Change Score	

APPENDIX TABLE—Continued

Study: Authors and Date	Patients Sampled: Medical Problem or Procedure	Nature of Experimental Group Intervention; Duration; Provider	Sampling Method: n_1 = size of experimental group[a] n_2 = size of control group[b]	Outcome Indicators	Outcome Effect Size: (ES) (+ favors Experimental Group)
Stockdale[32] (1975)	Assorted surgery	operation, mean duration 13.4 min. by "The experimenter"	$n_1 = 22$ $n_2 = 21$	1. From pre-therapy to immediate post-therapy	+ .27
				2. From pre-therapy to night after surgery	+ .23
Rahe, O'Neil, Hagan, et al.[33] (1975)	Adults: Mycardial infarction	Four to six group therapy sessions, psychiatrist, during early rehabilitation	Mostly random, well-matched $n_1 = 36$ $n_2 = 21$	a. Number of coronary disease events 18-month follow-up post-infarction[c]	
				1. Coronary insufficiency	+ .61
				2. By-pass surgery	+ .63
				3. Reinfarction	+1.16
				4. Mortality	+ .58
				b. Knowledge of etiological factors in heart disease	+ .79
Field[34] (1974)	Adults: Orthopedic surgery	Hypnotherapy recording by "Research Assistant" who interviewed patient, 20 minutes plus interview	Random: $n_1 = 30$ $n_2 = 30$	a. Nervousness (rated by physician)	+ .37
				b. Speed of recovery	+ .06
Surman, Hackett, Silverberg, et al.[35] (1974)	Adults Cardiac surgery	One or more therapeutic interviews, including teaching of autohypnosis 60–90 minutes	Random: $n_1 = 20$ $n_2 = 20$	a. Post-op Complications	
				1. Delirium	+ .15
				2. Cardiac failure	− .11
				3. Hepatic dysfunction	+ .60
				4. Arrhythmias	0.00
				b. Post-op Medication	
				1. Narcotic doses	− .41
				2. Morphine units	− .30
				3. Darvon doses	− .02
				4. Sleep medication	− .11
				5. Valium amount	+ .16
				c. Patient's State 5 days post-op.	
				1. Anxiety	− .14
				2. Pain	− .40
				3. Depression	− .75
				d. Days hospitalized[d] Exper. = 13.4 days Control = 17.0 days	—
Vernon and Bigelow[36] (1974)	Adult Males: Hernia repair surgery	Information recording re: hernia surgery and recovery heard twice pre-surgery plus encouragement to ask questions (investigator not specified)	Random: $n_1 = 20$ $n_2 = 20$	a. Pre-op.	
				1. Mood[c]	
				(1) Fear	0.00
				(2) Worry or fear of pain	+ .78
				2. Patient's confidence in doctors and nurses	+ .27
				b. Post-op.	
				1. Mood[c]	
				(1) Anger	+ .14
				(2) Depression	+ .36
				(3) Fear	+ .16
				2. Confidence in doctors & nurses	+ .22
Vernon and Bailey[37] (1974)	Children: Minor elective surgery	Film showing children going through induction of anesthesia without fear, approximately 45 min. by MD investigator	Random: $n_1 = 19$ $n_2 = 19$	a. Global Mood Scale, fear rating	
				1. Entering operation suite	+1.11
				2. Entering operating room	+1.10
				3. First minute of surgery	+ .70
				4. Until surgical anesthesia level reached	+ .50
				5. Anesthesiologist's rating of patient's fear	+ .46
Schmitt and Wooldridge[4] (1973)	Adult males: Elective surgery	Nurse investigator's small group therapy session evening before surgery. 1 hour for 19 experimental subjects; and added individual 15 to 60 min. session with nurse the morning of surgery.	Random: $n_1 = 25$ $n_2 = 25$	a. Self-report of anxiety on morning of surgery	+1.73
				b. Ability to void post-op.	+1.50
				c. Post-op. blood pressure	+1.10
				d. Amount of analgesics used	+ .78
				e. Number of days to resume oral intake	+ .21
				f. Days hospitalized post-op.	+ .55
Lindeman and	Adults: Elective	Pre-op. visits by operating	Random:	a. Days hospitalized	− .02

APPENDIX TABLE—Continued

Study: Authors and Date	Patients Sampled: Medical Problem or Procedure	Nature of Experimental Group Intervention; Duration; Provider	Sampling Method: n_1 = size of experimental group[b] n_2 = size of control group[b]	Outcome Indicators	Outcome Effect Size: (ES) (+ favors Experimental Group)
Stetzer[39] (1973)	surgery	room nurses; reassurance and information	n_1 = 90 n_2 = 86	b. Analgesics used within 48 hrs. post-op.	− .22
				c. Problems in emerging from anesthesia	+ .23
				d. Anxiety pre-op.	+ .09
				e. Anxiety post-op.	+ .19
	Children:	Structured pre-op. teaching by nurses	Random: n_1 = 19 n_2 = 11	a. Days hospitalized	+ .30
				b. Anelgesics used within 48 hrs. post-op.	+ .56
				c. Problems in emerging from anesthesia	+ .36
				d. Anxiety pre-op.	+ .21
				e. Anxiety post-op.	+ .46
Lindeman and Van Aernam[40] (1971)	Adults: Chest and abdominal surgery	Structured pre-op. teaching by nurses	Random: n_1 = 126 n_2 = 135	a. Days hospitalized	+ .34
				b. Analgesics used within 48 hrs. post-op.	− .02
				c. Maximal expiratory flow rate	+ .47
				d. Vital capacity	+ .35
				e. One second forced expiratory volume	+ .35
Aiken and Henrichs[41] (1971)	Adult males: Heart surgery	Modified systematic desensitization (Wolpe and Lazarus) Nurses, plus 15 min. tape recorded relaxation exercise	Matched: n_1 = 15 n_2 = 15	a. Psychosis post-op.	+ .87
				b. Anesthesia time	+ .72
				c. Units of blood	+1.00
				d. Degrees of hypothermia	+1.03
				e. Duration of hypothermia	+ .62
				f. Mortality (3/15 = 3/15)	0.00
				g. Minutes on bypass machine	+1.41
DeLong[42] (1971)	Adults, female: Elective abdominal surgery	Specific information about condition, surgery and recovery given by psychologist	Random: n_1 = 31 n_2 = 33	a. Days hospitalized	+ .54
				b. Physical recovery	+ .65
Layne and Yudofsky[e] [43] (1971)	Adults: Intracardiac surgery	Therapeutic interview evening before surgery	Sample of convenience: n_1 = 42 n_2 = 19	a. Psychosis post-op.[c] Exper. = 10% Control = 22%	+ .51
Andrew[e] [44] (1970)	Adult males: Hernia surgery	Informational tape recording, 8 minutes, by psychologist	Sampling method unclear: n_1 = 22 n_2 = 18	a. Days hospitalized	− .04
				b. Amount of medication	+ .11
Healy[e] [45] (1968)	Adults: Abdominal surgery	Preparation for post-surgical experience, by nurse	Sampling method unclear: n_1 = 181 n_2 = 140	a. "Discharge earlier than norm"[e]	+3.28
				b. Narcotics required[e]	—
				c. Post-surgical complications	+ .92
Lazarus and Hagens[e] [46] (1968)	Adults: Open-heart surgery	Interview 1 hr. plus consultation with staff and changes in recovery room procedures	Sample of convenience: groups in two different hospitals n_1 = 21 n_2 = 33	a. Per cent patients with psychosis post-op.[c]	+ .65
Cassell[47] (1965); Cassell and Paul[h] [48] (1967)	Children: Cardiac catheterization	Puppet therapy before and after catheterization; child clinical psychologist.	Random: n_1 = 20 n_2 = 20	a. Disturbance during catheterization	+ .82
				b. Willingness to return to hospital	
				1. 3 days post-op.	+ .08
				2. 30 days post-op.	+ .23
				c. Behavior adjustment post-hosp.	
				1. 3 days	+ .08
				2. 30 days	+ .05
				d. Days 1 and 3 observation	
				1. Mood	+ .40
				2. Anxiety	+ .36
				3. Anxiety	+ .86
Mahaffy[f] [49] (1965)	Children: Tonsilectomy and ad-	Information and support to mothers by nurse at admis-	Random: n_1 = 21	a. Post-op.	
				1. Ability to take fluids orally	+1.95

APPENDIX TABLE—Continued

Study: Authors and Date	Patients Sampled: Medical Problem or Procedure	Nature of Experimental Group Intervention; Duration; Provider	Sampling Method: n_1 = size of experimental group[b] n_2 = size of control group[b]	Outcome Indicators	Outcome Effect Size: (ES) (+ favors Experimental Group)
	noidectomy	sion and when child returns from recovery room.	n_2 = 22	2. Vomiting	+1.12
				3. Crying before bedtime	+1.01
				4. Crying after bedtime	+ .90
				b. Post-hospital Questionnaire	
				1. Fever	+ .84
				2. Called doctor to home	+ .52
				3. How long before child "recovered"	+ .79
				4. Child's behavior worries mother	+ .83
				5. Child's sleep disturbed	+1.31
				6. Fear of doctors and nurses	+ .36
				7. Fear of leaving mother	+ .28
				8. Crying	+ .30
Dumas and Leonard[e] [50] (1963)	Adult females: Gynecologic surgery	Nurse visited one hour before surgery, accompanied patient to surgery and remained until the patient was on OR table.	Unspecified: n_1 = 31 n_2 = 31 Total over 3 experiments	a. Post-op. vomiting[c]	+1.10
Kolouch[e] [51,52] (1962, 1964)	Adults: Elective surgery	Hypnotherapy prior to surgery and suggestion while patient still under anesthesia; by surgeon investigator.	Sampling method unclear: 100 cases selected by experimenter	a. Post-operative analgesics[d]	—
				b. Days hospitalized[g]	+ .70
Egbert, Battit, Welch, et al.[5] (1964)	Adults: Abdominal surgery	Information and reassurance by the anesthesiologist night before surgery plus visit by the same anesthesiologist post-surgery	Random: n_1 = 51 n_2 = 46	a. Amount post-op. morphine[j]	+ .51
				b. Amount of pain[j]	+ .40
				c. Days hospitalized	+ .67
Bonilla, Quigley and Bowers[e] [53] (1961)	Adult males: Knee surgery	Hypnotherapy pre-surgery by operating surgeon, 100 minutes total except for post-surgical hypnotism needed for 2 patients	Consecutive cases for each group: n_1 = 9 n_2 = 40	a. Average rehabilitation time[k]	+1.31
				b. Post-op. narcotic[d]	—
Vaughan[e] [54] (1957)	Children: Strabismus surgery	Reassurance and explanations by surgeon on admission for 15–25 minutes, repeat visits by surgeon 3rd and 5th days post-op., for 10–15 min.	Matched: n_1 = 20 n_2 = 20	a. Disturbed behavior[c]	
				1. Immediate post-op.	+ .37
				2. 7 days post-op.	+ .90
				3. 26 weeks post-op.	+1.15
Goldie[e] [55] (1956)	Adults and Children: Requiring surgery or orthopedic procedure in ER	Hypnosis treatment as adjunct to or substitute for anesthesia; the physician handling the patient.	Sample of convenience: n_1 = 210 n_1 = 178	a. Administration of general or local anesthetic for[c]	
				1. Incisions	+ .31
				2. Removal of foreign body	+ .89
				3. Suturing	+ .47
				4. Reducing fracture or dislocation	+1.34

FOOTNOTES TO APPENDIX TABLE

[a] Some authors published more than one article about the same studies and from these, only non-duplicated findings are reported. Studies that tested the effect of emotional support for a mother on recovery of child-patient were included. Studies that tested the effect of support for a mother of a child-patient on the subsequent comfort of the mother were not included.

[b] The group sizes for some studies change slightly for different outcome variables.

[c] Values transformed from percentages to metric numbers by probit transformation.

[d] Means and standard deviations needed to compute ES not available in published study.

[e] These ESs are derived from studies that did not assign patients to experimental and control groups randomly or through adequate matching or are approximated through probit transformation. They are excluded from the analysis reported in Table 2.

[f] Only the outcome variables listed were reported in sufficient detail to permit computing ES.

[g] This largest ES for hospital stay was computed from probit transformed dichotomous data. The author does not describe how the "norm" for expected hospital stay was determined. The analysis reported in Table 2 omits this finding.

[h] Three outcome measures relating to recall of surgery are omitted. The ESs are large and favor the intervention group but the benefit of recall is uncertain. The same findings are reported in Cassell's study.[47]

[i] Author reports findings for five types of surgery but data are sufficient to permit computing ES for only two—hernia and thyroid. We present the average ES for these two as a conservative estimate of the effects obtained.

[j] Authors report 24-hour morphine usage for five post-op. days and four measures of post-op. pain. Since the ESs are quite similar and redundant, we substitute the average ES for each set. The S.D.s needed to compute the ESs could be estimated from the data presented.

[k] S.D. could be estimated from other data to compute ES.

EDITORIAL COMMENT ON THE MUMFORD, SCHLESINGER AND GLASS ARTICLE

In their article, "The Effects of Psychological Intervention on Recovery from Surgery and Heart Attacks: An Analysis of the Literature," published in this issue of the Journal,[1] Mumford, Schlesinger, and Glass have made an important contribution to our understanding regarding the role of interpersonal skills in medical and surgical care. Most residency training programs have been designed so that knowing when and how to perform a procedure or which medicine to prescribe are adequate abilities. Skills in communicating with patients have generally been viewed as necessary, but unimportant or placebo aspects of patient care which are learned through experience. As the "art" of medicine, such techniques cannot be scheduled nor taught, or so the stereotype goes; and they have no particular influence on patient outcomes. This careful review article sheds serious doubt on such notions.

The authors have drawn on a widely distributed literature for their review. Reports came from journals which serve primary care physicians, pediatricians, internists, surgeons, psychiatrists, immunologists, psychosomatic medicine, anesthesiologists, dentists, nurses, psychologists, and medical social scientists. The isolation of these investigators in a variety of fields has probably impeded their influence on medical and surgical practice.

Another valuable contribution by the authors has been to subdivide the general area of interpersonal skills management into: 1) education and 2) one-to-one interactions, such as discussion regarding the patient's questions and concerns—sometimes referred to as counseling or (in mental health jargon) supportive psychotherapy. Lumping all interpersonal skills into one broad category serves only to obfuscate the complex issues involved. It is of interest that the data support the utility of applying both approaches, rather than employing just education or just a psychotherapeutic modality.

What are the implications of these findings for the health field? First, we must be much more concerned about training health professionals in interpersonal skills, such as education, counseling, and relaxation techniques. This is especially true for those fields in which the primary emphasis has been on the acquisition of biomedical information and technical skills. These disciplines include dentists, most physicians and surgeons, and many nurses. This is not to say that these professional groups must become "compleat" psychotherapists; however, they must be able to educate and counsel patients about the medical interventions and technical procedures which they perform. Merely exposing students and trainees to experienced clinicians does not guarantee either that they will acquire interpersonal skills adequate to their tasks, or that they will understand the importance of such skills on patient outcomes. In this regard, the National Board of Medical Examiners has recently established an Interpersonal Skills Task Force to generate test items which address this important area.[2] It appears that, at least at the level of certification and licensure, there is a growing awareness regarding the importance of these skills for professional competence.

An important corollary issue involves the assignment of clinical responsibility for interpersonal skills in health services. It seems likely that in time both consumers as well as administrators of health services will recognize the importance of such transactions to patient outcomes. If health professionals do not discharge these responsibilities during their provision of services, it seems likely that others will be hired and trained to meet them. This can only add to the cost of medical care, as well as to the fragmentation and depersonalization of health services.

Another implication of this report concerns economics. The authors have demonstrated that the provision of education and brief psychotherapies tended to reduce cost, while also reducing morbidity and mortality. Yet, the recent trend in health care insurance has been to reduce or refuse recompense for such services. It is not likely that a fee submitted by a physician or surgeon for counseling or education would be honored, nor that a hospital administrator would permit nursing time to be devoted to similar endeavors. Thus, our current economic, political, and administrative structures obstruct the implementation of these findings.

As with most innovative studies, these findings raise new issues for us. In particular, further attention should be paid to the minority (15 per cent) of the findings which do not support the hypothesis. As the authors indicate, we should not assume that education and counseling are necessarily good for everyone despite general trends. We need to know when the application of these interpersonal skills is either unnecessary or even counterproductive. So-called Hawthorne effects, stemming from such nonspecific factors as increased staff-patient interactions, may account for much or all of the observed differences. There remains the possibility that other data supporting the null hypothesis have not been published, given the difficulty in publishing such reports.

Many humanistic and/or experienced clinicians will view these data as merely explicating the obvious. For many others involved in the provision of health services, the results are not so obvious. As the Chinese-American medical anthropologist Francis Hsu has observed, "The Chinese accept science if it is clothed as magic, while Americans accept magic if it is clothed as science." Many health practitioners view the application of interpersonal skills in clinical interactions as evidencing more of the magic of medicine rather than its skillful and scientific application. We need such studies as these to provide enlightened and effective health services which are both humanistic and scientific.

JOSEPH WESTERMEYER, MD, MPH, PhD

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Chairman JACOBS. Thank you, Doctor.
Dr. Primich.

STATEMENT OF FRANK J. PRIMICH, M.D., MEMBER, BOARD OF TRUSTEES, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC., AND CHAIRMAN, AD HOC COMMITTEE ON PRESENTATION OF THE MEDICAL SOCIETY OF NEW JERSEY DRG POSITION

Dr. PRIMICH. I am Dr. Frank Primich, speaking on behalf of the Association of American Physicians & Surgeons and very specifically as spokesperson for the Medical Society of New Jersey.

The physician group is better able than anyone else who has testified here to make a judgment as to the value and validity of the program in New Jersey.

The proposed purpose of New Jersey's Public Law 1978, chapter 83, was to adjust perceived inequities in hospital cost to the various categories of bill payers and resolve the uncompensated cost.

DRG represented an innovative methodology that would facilitate the rate setting process, accomplish cost containment, improve the quality of care and upgrade physician performance, demonstrate value and validity of prospective payment, and correct the preexisting cost shift inequities.

DRG's have not and cannot accomplish any of the above. DRG's were introduced as a voluntary limited experiment that was arbitrarily extended statewide without any evaluation. Still unevaluated, they have been projecting as a successful model for other States to follow. This experiment defies all criteria for experimentation.

Claims for success are at best deceitfully premature and at worst, outright lies. Were it to be shown medicare costs were lower, the gains would be minuscule compared to the increased cost of regulation, conversion, and compliance and cost shift of a new and more ominous nature.

New Jersey Blue Cross premiums last year went up 46 percent and Blue Cross complained that was not enough for them to maintain solvency.

The appeals process has become a joke in New Jersey. The ratesetting commission solution to this, because of the fact that as far as the prospective payment concept is concerned in New Jersey where DRG's started with 26 hospitals in 1980, as of December 1982 only three of those original hospitals had had a final reconciliation on their supposedly prospective rates, three more were finalized in December 1980, had itself entering in 1983 with 6 out of 26 hospitals reconciled.

Now, this in no way projects anything that is of any value as far as making judgments for the future. Now, the rates commission has taken some arbitrary actions. They have openly discouraged the appeals process. They have offered a 1-percent bonus to any hospital who accepted what they offered.

They have also retained the prerogative for anyone who does appeal, no matter how legitimate an appeal, to recalculate the original offer with a different formula that supposedly would guarantee that the figures came in 2 to 3 percent lower than the original.

Now, these tactics are hardly what one would expect in a country where there are presumably some freedoms left. For 1983 it has been a long time projecting their budgets. Prospective rates came out. There was a miscalculation on what I referred to as the COLA aspect; in other words, cost of living inflationary factor for the previous year.

This is one proposed by the rate setting commission, 9 percent. The figures now came out to be 7 percent.

Retrospectively, though, the hospital based their budgeting on those figures given to them. They are now being penalized 2 percent on their 1983 rate to make up for that error by the ratesetting commission.

The whole concept is horrendous. The only saving grace is that it absolutely shows the central planners and regulators have no concept and no ability to project prospective payments. This is a farce.

The medical society asked the Department of Health and Human Resources to impartially evaluate for any evidence there has been improved health care or improved physician performance.

There has been no answer to this day.

We have also asked for final figures. They are not available. Without these figures being available, we have the projection of this tremendous cost savings. This is a one sided mathematical formula. There is nothing in it that balances out the cost.

As I have said before and as is in my written, submitted testimony, we go into this at greater length.

Why is such a bad program being projected? There are a few winners. The losers, mind you, are the insurance subscribers and payers, the people who pay insurance premiums are terrible losers. The aged and infirm patients will be deprived of care by de facto rationing and there is no way that this system will prevent that if it is implemented.

My recommendation is that the whole concept be scrapped, that it be recognized the Government has promised more than it can pay for. It should be honest enough to do one or two things.

Tell the people they can't pay for it or raise their taxes to let them see what they are paying, not through the pockets of insurance subscribers or some other devious capacity of changing the funding of health care.

[The prepared statement follows:]

STATEMENT OF FRANK J. PRIMICH, M.D., ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC., AND THE MEDICAL SOCIETY OF NEW JERSEY

Mr. Chairman, members of the Committee, interested parties, innocent bystanders; My name is Frank J. Primich, M.D. I have been a practicing physician in New Jersey for over thirty years. Throughout that time I have firmly believed that it was my responsibility to my patients, not merely to diagnose and prescribe, but to protect them against external forces which would adversely effect their health and welfare.

I am testifying formally on behalf of the Association of American Physicians and Surgeons, a national organization dedicated to the preservation of the patient-doctor relationship of private fee-for-service practice, and resistance to intrusion into that relationship by any third parties, particularly government. Formally, I am also representing the Medical Society of New Jersey, the oldest state medical society in the nation.

If these hearings follow the format of comparable state-level hearings in New Jersey, the preponderance of testimony will be submitted by those who see themselves as "winners" in this issue. I beg your indulgence, to permit me to also speak, as one of them, for the certain "losers"; the over 2,000,000 New Jersey Blue Cross subscribers, the even higher number of New Jersey tax-payers, and the more than seven million potential patients in my state.

I would like to acquaint you with the New Jersey "experience". Note that I do not refer to it as an "experiment", the commonly heard misnomer. What has been perpetrated in New Jersey meets none of the moral, ethical, nor scientific criteria of an experiment. As is so often the case, a well-intentioned piece of legislation has been distorted in its bureaucratic implementation to the point where the results are worse than the original problem.

In evaluating some of the other testimony you will hear, particularly statistical material, you should be reminded that prior to the institution of the present New Jersey program, our state was already among the most over-regulated regarding hospital rates.

New Jersey Public Law, 1978, Chapter 83 proposed to resolve the perceived inequity in hospital costs to the various catagories of bill payors, and to further resolve the "uncompensated cost component" of hospital billing; over $100,000,000 annually.

Diagnosis Related Groupings (DRGs) were seen as a bizarre disruptive innovation with only one "valid" favorable aspect. Federal regulations would not permit the necessary alterations in Medicare and Medicaid rates, except in conjunction with an innovative "experiment". At that point in time the term was certainly applicable. Its sponsors convinced the Health Care Financing Agency that their methodology would:

(1) facilitate the rate-setting process;
(2) accomplish cost containment;
(3) improve quality of care, and upgrade physician performance;
(4) demonstrate the value and validity of "prospective payment";
(5) correct the pre-existing "cost shift" inequities

DRGs have not, and cannot, accomplish any of the above.

DRGs were introduced in New Jersey as a voluntary limited experiment. As such, despite misgiving regarding the outcome, MSNJ gave conditional approval to the program. Voluntary was the first word to go. The program started in 1980 with 26 hospitals. Only ten volunteered, so sixteen others were "selected" to give the "necessary case-mix". Limited didn't last much longer. Before the initial group was even organized, it was announced that an additional 40 hospitals would be added to the program in 1981, with all the rest scheduled for 1982 entry. Experiment, is the term which best illustrates the insincerity of the bureaucrats. An experiment, of any type, must be evaluated by the results, before claims can be made of success. The New Jersey program was expanded statewide without any evaluation. It is now being projected nationally as a successful model to follow. Its only success, to date, is that the people haven't risen up in rebellion. They can thank the press and media which mindlessly pass along the false optimistic claims of the Department of Health.

The Health Research & Education Trust (HRET), the supposedly impartial evaluation organization, currently rates the available information as inconclusive! This is a group composed of and supported by those whom I contend fancy themselves as among the "winners". There is no representative of those who pay healthcare insurance premiums, nor those who pay their own bills. There is no representative of patients who will be subjected to sub-standard care and de facto rationing. There is no true representation of practicing physicians who saw, now see, or will eventually see the devasting effects this abysmally impersonal approach to hospital care fosters.

To any individual who prides himself in being open-minded, it is frustrating to hear repeatedly, from supposedly authoritative sources, that the DRGs have good and bad features. This implies that final judgment of their merits must await some retrospective evaluation in the distant future, hopefully, beyond the statute of limitations which might hold those responsible who initiated this stepping-stone on the road to Socialized Medicine. The non-judgmental approach implies a balance between good and evil. When the good accrues to relatively few, and the damage is spread over all the rest, the scales of justice tip precipitously. In a Socialistic or Totalitarian society such actions are commonplace. If they are tolerated here, our other cherished liberties shall be further endangered.

Let us first look at the supposed good features. No one can deny that it is a boon to the computer industry. It would appear to help alleviate the unemployment problem, since more people become necessary in the business offices of hospitals, not to mention the bureaucrats needed to play out the charade. It offers the statisticians on both sides of the discussion an almost infinite supply of numbers to play with, so varied and abstract as to permit any conclusions imaginable. It should absolutely identify those providers who grossly overutilize hospital facilities. It is hoped to have an educational impact upon those physicians who practice bad medicine. It is projected as the only regulatory vehicle which meets the bizarre requirements for the Medicare-Medicaid waiver, without which N.J.P.L., 1978, c.83 would be doomed. It, therefore, would permit the equalization of hospital billing intended by the Legislature, and eliminate "cost shifting". It is one approach to assuring survival of inner-city hospitals and those institutions whose inept management has placed them in jeopardy.

Now, let's examine these suppositions in reverse order:

Subsidization of ineptitude can only lead to its perpetuation.

Inner-city hospitals have arrived at their deplorable state, in large part, because of the false promise of high quality care for all, projected by politicians who had little appreciation or concern for the ultimate cost. To bail them out by increasing taxes would be very unpopular and politically hazardous.

Cost shifting, the problem supposedly addressed by N.J.P.L., 1978, C.83, turns out to be replaced by a more onerous cost shift.

Discounted rates for Blue Cross, Medicare, and Medicaid had made it necessary for hospitals to raise their rates to commercial insurers and self-pay patients in order to break even. Though the theory overlooks some significant factors, it would seem fair that all payors pay the same amount for the same service. This loses its element of fairness when the factor of the annual $100,000,000 plus in uncompensated costs is brought into the equation. These costs, which Big Brother has benevalently proposed to underwrite, were to now be pro-rated among the various payors.

Blue Cross, with over 2,000,000 subscribers in New Jersey, has been forced to raise its premiums in 1982 by over 40 percent, with the threat of more to come. The taxpayer is being "Spared" by paying out of his other pocket as a health insurance subscriber. This is not merely a "cost shift". It turns out to be "blame shift" as well. The hostility of the victims of this shell game is focused upon the insurance companies and the healthcare providers who are charging such "unconscionable fees".

This same scenario applies to all other "prospective payment" proposals, not just DRGs.

The Medicare-Medicaid waver deserves condemnation in passing. It permits the Federal government to pay "a little more" than prior rates, but stipulatesd that if costs are higher than under the old system, the hospitals will be responsible for return of the difference. There is no such protection available to insurance subcribers or self-payors. Preliminary reports show most New Jersey hospitals exceeding their Medicare caps. They have been told not to worry. If the Federal government doesn't press Poland and Mexico regarding their indebtedness, why would it pick on our own hospitals? I tried that logic with the IRS, and it didn't work!

Gross overutilizers and bad practitioners are well known and easily recognized in any institution. Fortunately, they are few in number. If there were a genuine desire to weed them out, there are far simpler ways of doing it than mandating "cookbook" medicine for all physicians and patients.

Increased employment and computer utilization sounds facetious. Any humorous overtone fades when you realize the simple economy dictates that more clerical help be reflected in less employees directly involved in patient care. Computerization means that you, as an individual, will be converted to a number. Not even your Social Security number, if you are not exempt from that scam, but your DRG disease designation. Faced with the need for expert medical treatment, wouldn't you prefer the doctor of your choice, and the assurance that your care would be determined by his, or her, best judgment? Since the primary concern of this Committee is the feasiblity of prospective payment programs which might contain Medicare costs, let me dwell on that subject for a moment. New Jersey's current experience suggests that any paper savings regarding Medicare costs would require unmedical doctoring of the figures. In the event that such evidence is offered to you, I contend that any "saving" would be minuscule compared to the increased costs of regulation, conversion & compliance, and the already mentioned new "cost and blame shift". The average taxpayer can be deluded by references to his money, local money, state money, and federal money. You are well aware of that shell game which diverts attention from the major issue. If we are to be concerned about the cost of healthcare, and we certainly should, it is the overall cost that must be addressed. Disrupting the entire healthcare system to achieve an unrealistic cosmetic effect would be a gross disservice to your constituents. Applying any of the proposed programs to Medicare patients would be costly to everyone. Extending the process to all patients, an inevitable next step, in the name of cost containment would compound the travesty.

MSNJ fell into the early trap of trusting bureaucrats. We have recovered, and have a remarkable unanimity of agreement regarding the hazards of prospective rate-setting as practiced in New Jersey. We are desparately alerting the rest of the country.

The New Jersey Hospital Association originally opposed the program. It shifted to a position of neutrality because of inner conflict, and then chose to supprot DRGs with the misguided delusion that they would have better bargaining power. It has taken a few years to show their folly, and will take a few more before they admit their error. Initial allowances, the carrot, were fairly reasonable. Loopholes abounded, and most hospitals showed a "profit". Then came the stick. Tightened rates and coersive threats regarding appeals changed the picture drastically. One hospital showed a profit of $3 million in 1981, broke even in 1982, and projects a loss for 1983. Another made over two million in 1981, lost a little in 1982, and is concerned about insolvency in 1983. These are not exceptions. They are the rule. Jersey City Medical Center, which was to have been one of the major beneficiaries of the program declared bankruptcy. The courts have declared them ineligible for that escape route, but none the less the hospital is broke. There will undoubtedly be a bailout, not surprisingly at the taxpayers expense.

The appeals process was initially overwhelmed by largely justifiable complaints. Even cursary attention to these complaints rendered the whole concept of prospective payment inoperable. Final reconciliation for the original 26 hospitals which entered the program in 1980 were concluded for three in December of 1982, bringing the total to six of twenty six at last count.

The quick fix for this problem is rather significant as to what can be expected. The 1983 proposed rates are accompanied by an offer of a 1% bonus if accepted. At a seminar attended by fiscal officers from most of New Jersey's hospital in November 1982, Jeff Warren of the rate-setting Commission informed the audience that the Commission was annoyed by appeals, would be inclined to reject most, and suggested that they grab the 1 percent bonus while they could. They were further told that if they chose to file appeals, the Commission reserved the right to withdraw the original rate package, and submit a new proposal, calculated by a different formula, which could be expected to average out to several percentage points lower than the initial offer. This highhanded attitude threatens to wipe out the appeal process, making the rate-setting process dictatorial, without recourse.

Lest anyone think that the 1 percent bonus should be adequate to correct any minor oversights, let me present the following case. Middlesex County Hospital entered the program in 1982. They appealed $9,000,000 in assorted items. At last count, the "unfriendly" rate-setters had approved $7,000,000, disapproved $500,000, and were still negotiating the remaining $1,500,000.

After hospitals had spent months calculating their 1983 budgets, the stringent 1983 proposed rates arrived. Since retrospective calculations showed the projected COLA type allowances for 1982 to have been in error (7 percent, rather than 9 percent), the 1983 rates were to be lowered by that 2 percent difference. The fact that 1982 and 1983 expenditures, particularly salary increases had been based on the Commission's erroneous estimate apparently doesn't matter. The hospitals are to be held accountable for the error. The silver lining to that cloud is that it should prove to those who need concrete evidence that central regulators are incapable of accurate projection.

In addition to my other duties I am President of the Medical Staff of Riverside General Hospital in the Hackensack Meadowlands. Riverside is the sole remaining proprietary hospital in New Jersey. The rate-setters refuse to permit any further allowance for return on investment. As a result this highly successful and highly respected institution will be forced to sell. So much for competition and Free Enterprize in New Jersey. Meanwhile, the altered calculations make it imperative that the 1983 budget be cut by $500,000. We are being asked to cut services to whatever degree is possible, think twice about potential cost-overrun admissions and discharge marginal cases early. Next year these pressures can be expected to be stronger. In other institutions, they already are. Orwell's 1984 comes next.

MSNJ has repeatedly requested in writing to be informed by the state Department of Health and the HRET evaluation team of any evidence that the quality of care has been improved. For obvious reasons, there has been no response.

I trust that you have been given copies of Volume 1 of the HRET DRG Evaluation. Despite my misgivings regarding the composition of the organization, their report is most enlightening, in a negative way. Don't be overwhelmed by its bulk. It can be catagorized best as underwhelming. 33 of the 80 pages are devoted to the bibliography. Most of the references are technical, theoretical, and questionable. 14 additional pages are tables which report on 3 serial surveys of participating hospitals. Failures of response and high "no opinion" percentages make the statistical validity suspect. My favorite is the question as to whether the DRG method of allocating costs is reasonable. 23 1981 entries into the system answered as follows: 30.4 percent Yes, 30.4 percent No, and 39.1 percent No Opinion! If that had been an election, "none of the above" would have won.

The double-spaced text is an easily readable 31 pages. The conclusions, half of page 31, are all that is really significant. As I have already noted, they are inconclusive. A vital question is raised as to whether the costs of compliance and implementation may not be greater than projected claims of cost savings. No mention is made of the regulatory costs. It is my belief that once total costs are computed, there will be a tremendous negative balance. As a cost containment program it is not cost-effective. The interminable wait for absolute confirmation of that fact will permit irreparable damage to the traditional concepts of healthcare financing. State Senator Garrett Hagedown best summarized the program when he asked a Department of Health witness, "Are you telling me that you want the health insurance subscribers to subsidize the costs of Welfare?" There was no denial.

Hospitals, in every category, are coming to realize that they will not be among the ultimate "winners", but they are still trying to make the best of a bad situation. Commercial insurers see the system as giving a competitive edge vis a vis Blue Cross, and Blue Cross is afraid to complain. Rates for both must continue to rise. The only real winners are the bureaucrats and the politicians. They continue to make a comfortable living, screwing up other people's lives.

I'll survive, because I'm tough. The hospitals will survive, because they must. The aged and the inform are the biggest losers. They will succumb to what will be referred to as fiscal euthanasia, but, unfortunately, it will be far from painless.

Chairman **Jacobs**. Mr. Duncan.

Mr. **Duncan**. I have no questions. Thank you, Mr. Chairman.

Chairman **Jacobs**. Dr. Primich, this business about medical care inflation outstripping the normal regular inflation rate, is that all a bad dream?

Dr. **Primich**. It has outstripped it. There are a number of factors that are unique to the health profession.

No. 1, for many, many years nurses and ancillary hospital employees were dedicated people who were willing to work for salaries that were not commensurate with other things. The fact of nursing shortages caused marked increase in nurses' salaries. They are still not being paid what they are worth, but that element came up.

Menial employees due to minimum wage laws are being paid more than what they used to be paid or what they were worth. When you add these, the malpractice element, there is an element, there is no question there is some waste and inefficiency in the health care industry.

However, if you look at all the factors involved, that is minimal. Even if you could successfully address it, it would not impact on the major problem that we face.

To me it seems rather presumptuous for the Government who perhaps is the most wasteful and inefficient of any group in this country to imply that they are able to inflict some type of efficiency upon the health care system.

The health care system is a lot better than the Government. The physicians know a lot more about the health care system than the bureaucrats do.

Chairman **Jacobs**. Let us see. The Government is inflicting an awful lot of money on the health care system, too, so I expect the Government has some responsibility.

As I understand your answer, sir, it is pretty much caused by nurses and menial employees?

Dr. PRIMICH. That was just among the many. You asked for brevity. I did not want to list all the factors that are unique to the health care profession plus all the ones that are common to everyone else.

Chairman JACOBS. No other big factors that come to mind?

Dr. PRIMICH. The biggest single problem has been the increase in demand for health care. In other words, the first dollar coverage, the Government promised everyone is entitled to quality care, we hear of impossible dreams, that is an impossible promise.

Chairman JACOBS. Is there any regulation of that demand for health care?

Dr. PRIMICH. The closest regulation there is to it is the inability of its being adequately supplied. The law of supply and demand will solve this problem a lot faster than Government regulation ever will.

Chairman JACOBS. Can I go to the hospital if you don't say so?

Dr. PRIMICH. I think if you have to be in a hospital, I am sure you would find a doctor that would.

Chairman JACOBS. I go to a hospital if the doctor says no?

Dr. PRIMICH. If you are trying to prove the point

Chairman JACOBS. I am just asking the question.

Dr. PRIMICH. It is customary since we cannot have people just running in and checking in as they would to a hotel, that there should be some criteria for a patient to be admitted to a hospital. This is usually in the judgment of the admitting physician.

In most hospitals I have ever been associated with the idea is if this patient requires hospital care, he should be admitted.

Chairman JACOBS. What is this business about expanding demand? They needed it all along and didn't get it?

Dr. PRIMICH. Demand and need are slightly different. We are not in a position to address all the needs. We can't afford it.

Chairman JACOBS. You don't because you only admit people who are in need, don't you?

Dr. PRIMICH. Determining a person's need, sir, if you have not been faced with the problem that a physician faces, you have to take at face value what that patient tells you.

With the person who gives you all sorts of symptoms that may not even exist, you are hard pressed to be able to adequately disprove this and deny that admission.

Chairman JACOBS. If I were a trained professional, wouldn't I have some opinion about whether they were goldbricking?

Dr. PRIMICH. You would have an opinion, but God help you if you turn away a patient who impresses you as being a problem.

Chairman JACOBS. If I go to your office and say I feel terrible, I ought to be in the hospital, I just feel terrible all over, do I go to the hospital or do you do a little thumping and checking and listening?

Dr. PRIMICH. I do quite a few things. I happen to be an obstetrician and gynecologist. I have pumped a few chests in my time.

Chairman JACOBS. That is a very pregnant idea. If a woman comes to your office and says I am pregnant and the rabbit is in pretty good shape, that is a demand, don't you think that the medical profession has to take some responsibility for increased utilization? Just a little bit?

Dr. **Primich**. Just a little bit, precisely. That is the point. We should not take all the blame.

Chairman **Jacobs**. I didn't hear you getting any of the blame from you, Doctor.

Dr. **Primich**. I beg your pardon?

Chairman **Jacobs**. I didn't hear you getting any of the blame from you.

Dr. **Primich**. In New Jersey they are already defending their failure by saying the reason it has not worked is that they didn't have total control of the doctors, the doctors and their input in this is what makes DRG's not work.

Chairman **Jacobs**. I will try to say for the record that as long as I have been on this committee listening to testimony from the American Medical Association, I have always found it to be objective, responsible, and generally progressive.

But I don't understand your testimony, representing the American Association of Physicians and Surgeons, when I ask why there has been an inordinate inflation in health care costs, I do not understand testimony that says it is because of increased demand when in fact the medical profession has the responsibility to regulate that demand, whether it is by custom or however, that is the way it is.

I don't understand testimony that pushes the blame, passes the buck to the nurses or to the menial employees. That was true in 1965 when this program was passed; you said in the past few years. Surely there has been some catchup ball in that regard in the last 15 or 17 years.

I just say for the record that I generally appreciate and find very valuable your testimony, but I find this particular testimony somewhat asymmetric.

Dr. **Primich**. Sir, in its entirety the case can be made much better and to selectively pick those things such as the nurses and employees that I mentioned, there has, incidentally, been a secondary rise in nursing cost.

Chairman **Jacobs**. I have been informed that you, Dr. Primich, do not represent the AMA, so its record is pretty clear as far as I can see. I am sure you aim to do well.

So we thank you for your testimony. Thank you very much.

The next panel is Prof. William C. L. Hsiao, assistant professor of economics, Harvard School of Public Health; Mr. John Wilson, executive vice president, Rehabilitation Institute of Pittsburgh, Pittsburgh, Pa., National Association of Rehabilitation Facilities, American Academy of Physical Medicine and Rehabilitation Medicine, and American Congress of Physical Medicine and Rehabilitation.

Also, Mr. E. Winslow Turner, National Multiple Sclerosis; Mr. Harry Hall, Washington representative, member, government relations committee; and Dr. Merlin K. DuVal, M.D., president, Associated Hospital Systems.

Gentlemen, you know our procedures. Please proceed.

STATEMENT OF WILLIAM C. L. HSIAO, ASSOCIATE PROFESSOR OF ECONOMICS, HARVARD SCHOOL OF PUBLIC HEALTH

Mr. HSIAO. Mr. Chairman, my name is William C. L. Hsiao. I am an associate professor at Harvard School of Public Health.

I would briefly summarize the major points I made in my written statement for the committee.

There is much uncertainty surrounding the effects of the prospective payment system. As Mr. Jacobs has put it earlier, it is an uncharted minefield. You heard many contradictory statements about the potential impacts of the prospective reimbursement system. Some say there might be cost shifting, reduction in quality of care, and impairment of access; others disagree. Also you have heard other alarms raised. Many people have taken a strong stand on both sides of the issue.

Why is there so much disagreement and uncertainty about the effectiveness and impact of the prospective payment system?

The simple answers are: First, we do not know the fundamental causes of hospital cost inflation. Too often we have confused the symptoms with causes. We see a proliferation of technology or increases in number of nurses, and we say that is the cause for inflation, but actually they are symptoms of some causes which run much deeper.

Second, we do not know how the hospitals and doctors will respond to and behave under the prospective reimbursement system. We are in such a state of ignorance because there are few sustained long-term applied research and evaluation studies which shed light on this question.

The Government has long supported short-term studies on narrowly focused questions. They tend to be the most important and pressing issues before the administration or before Congress.

On the other hand, the administration has seldom supported sustained, long-term applied research, trying to discover what causes hospital inflation and how hospitals and doctors will respond to different kinds of reimbursement systems.

If this committee and the U.S. Congress want better and more reliable answers to the questions you have posed to the witnesses today, in other words, to chart this minefield, and to find credible predictions about what is the best way to reimburse hospitals and doctors, then I would recommend this subcommittee mandate the establishment of two or three long-term applied research centers to study the questions that are most important to this subcommittee.

I have spelled out in my written statement the details of how you can organize such centers and what kind of people must staff them so that the centers can address the real issues that are related to the reimbursement and financing of health care.

This morning, many witnesses made similar recommendations that we need to know more about the impacts of prospective reimbursement systems. They included the president of Blue Cross and Blue Shield and the American Nurses' Association. But they did not spell out how you can discover the knowledge that is necessary for this committee to legislate.

If my recommendation is adopted, with an expenditure of less than $5 million annually, I can assure the committee that you will have more factual information and basic knowledge on how the medicare program ought to reimburse hospitals. You will help the Congress and the administration in designing better and more effective reimbursement and financing schemes. I can assure you that such research efforts will generate savings that will be equal to at least 10 times the amount of money you invest.

[The prepared statement follows:]

STATEMENT OF PROF. WILLIAM C. HSIAO, HARVARD SCHOOL OF PUBLIC HEALTH

I am pleased to appear before you to testify on Medicare financing and hospital reimbursement. I have divided my remarks into four parts. First, I will briefly comment on the actuarial status of Part A of the Medicare program. Second, I will address what we know about the causes of the hospital cost inflation which places the Medicare program in such a precarious financial position. Then I will comment on the Administration's proposal to contain hospital cost inflation. But unfortunately there is little knowledge available for making reliable predictions of the impacts of this proposal. Lastly I offer a recommendation to aid your Committee in finding solutions to hospital cost inflation and to improve the financing of Medicare.

ACTUARIAL STATUS OF THE MEDICARE PROGRAM

In fiscal year 1983, Medicare will pay over $37 billion for hospital services. The rate of inflation in hospital costs for the Medicare program has averaged 15.8 percent annually from 1971-81. Since the inception of the program, the actuarial projections upon which its financing is based have consistently underestimated the cost of the Medicare program. The underestimation was not intentional, but rather resulted largely from hospital costs increasing much more rapidly than predicted. Current estimates show that even with optimistic assumptions about hospital inflation rates, the Medicare program has an actuarial deficit of 2.07 percent of taxable payroll (equals $28 billion per year on current dollars basis). Less than five years from now the Congress must provide additional funding because the Health Insurance Trust Fund will be depleted.

Because hospital cost inflation continues unabated, the Medicare program's deficit is likely to be much greater than is shown in current estimates. Additional financing will be necessary sooner. If the past hospital cost inflation rate, in real terms, continues in the future, financing of the Medicare program will become an enormous burden to American workers. Some experts have estimated that the program could cost $140 billion by 2010 (in 1983 dollars), or more than 10 percent of the taxable payroll. Congress is now confronted with twin problems: how to provide adequate financing for Social Security cash benefits and for Medicare. One effective way of reducing the financial burden of Medicare is by controlling hospital cost inflation.

CAUSES FOR HOSPITAL COST INFLATION

There is an abundance of guesses as to why hospital costs increase at in such a rapid rate. Everyone has his own pet theory. But in reality we have failed to identify the underlying causes. Often we have confused the manifestation with the cause. For example, experts and lay people alike have cited the adoption of new technology as a cause of hospital cost inflation. But that is like telling us that the American steel industry cannot compete because of its obsolete machinery. The basic question is why didn't the steel industry renew its plants with modern machinery. Was the cost of capital funds too high? Had the industry become an oligopoly, lacking the enterprising spirit necessary to adopt new production methods?

In the hospital field, there are a number of symptoms which people have mistaken as causes for the inflation. Among them are the increased sophistication of hospital services, without regard to need. Today more, hospitals have become tertiary hospitals with the adoption of high technology treatments for complicated illnesses. Most community hospitals now have intensive care units, coronary care units, nuclear scan, ultrasound, and CAT scan equipment. Moreover, there are more workers per bed, and more capital input per bed. While these symptoms have frequently been cited as causes for hospital cost inflation, the fundamental causes run much deeper. Yet, we have only a limited understanding of them.

A fundamental cause of hospital cost inflation that we can identify is the retrospective cost reimbursement system. Under this system, we provide hospitals with an open checkbook, and a promise that if they have actually incurred the cost, the third party payers will pay for it. It is obvious that the retrospective cost reimbursement offers no incentive for hospitals to economize or to coordinate services among themselves to serve the community. Instead, every hospital would prefer to install the most sophisticated equipment and offer the most prestigious medical services, provide the most hotel-like atmosphere and tasty meals, and construct the most aesthetically pleasing, architecturally award-winning building.

However, the retrospective cost reimbursement system is only one of the fundamental causes. According to research studies, 70 percent of a hospital's resource allocation decisions are made by doctors. They are the gatekeepers and the key decisionmakers in hospital care. Doctors decide which tests to order, how long a patient will remain hospitalized, and whether surgical procedures will be performed. In his report to the Congress, former Health and Human Services Secretary Richard Schweiker noted: "The demand for hospital admission and associated inpatient services is mediated by the physician who has little incentive to consider the cost or price of hospital inpatient treatment."

In fact, the physician's importance is even greater than Secretary Schweiker has described. Doctors not only decide, to a large extent, the use of current resources, but they affect future allocations when hospitals try to lure physicians by investing in attractive specialized facilities and services. Consequently, a fundamental cause of hospital cost inflation lies with the doctors, not hospital administrators. We can set maximum reimbursement rates, determine them retrospectively or prospectively, and try to control capital facilities expansion, but unless we learn how to directly influence clinical decisions we will not be able to reduce long-term hospital cost inflation.

Our ignorance about the fundamental causes of hospital cost inflation has impaired the nation's ability to contain medical cost inflation. We don't know the differential impact of prospective rate per case as compared to other reimbursement methods. We know little about the physician's role in the hospital and his influence on cost inflation. We don't know to what extent hospital administrators can affect clinical decisions. While we should try to deal with increased hospital costs to the best of our ability, despite our limited knowledge, at the same time we must seek to discover the fundamental causes. Only then can we fashion long-term solutions.

COMMENT ON THE ADMINISTRATION'S PROPOSAL

The Administration's proposal to reimburse hospitals at rates determined prospectively would introduce some incentives for hospital administrators to economize. This proposal takes a positive step toward containing hospital cost inflation. However, this proposed prospective reimbursement system could also produce certain adverse impacts. I believe that the Congress, under normal circumstances, will want to know the answers to the following questions before enacting new legislation:

(1) How much would the proposed system reduce the cost of hospital cost inflation as compared to the provisions passed under the TEFRA?

(2) How much would the proposed system reduce the cost of the Medicare program and thus improve its actuarial soundness?

(3) How would the proposed system affect access by Medicare beneficiaries to hospital services?

(4) How would the quality of hospital services be affected by the proposal?

(5) Who will gain and who will lose under the proposed reimbursement system? For example, would there be cost-shifting from the Medicare program to other payers? Would the financial health of hospitals decline?

(6) What are the differential impacts of the proposed system on urban hospitals, small rural hospitals, teaching hospitals, municipal hospitals, etc.?

To answer such questions, we must be able to explain both the fundamental causes of health cost inflation and how hospitals and physicians would respond to a new prospective payment system. Unfortunately, however, we lack sufficient knowledge to provide credible and reliable answers. This deficiency in our knowledge creates certain risks in adopting the prospective rate system.

First, there is no reasonable assurance that hospital cost inflation will be moderated by the proposed system. The demonstration projects which have yielded positive outcomes were largely established for all payers, not only for the Medicare program. From this limited experience, we cannot safely predict the impact of the proposed changes on hospital cost inflation.

A second potential adverse impact is that the proposed reimbursement system recognizes surgical procedures as an important component in establishing the per-case rates. Consequently, if an illness can be treated both medically and surgically, it will be more profitable for a hospital to treat it surgically. One possible outcome, then, would be for the hospitals to recruit more surgeons to fill beds and to produce financial surpluses. Since we have a surplus of surgeons in the U.S. and there are indications that too much surgery is already being performed, this prospective reimbursement system will exacerbate this problem.

Third, the exclusion of capital costs (including rent) from the determination of prospective rates will give incentives to hospitals to invest more and more in capital equipment and facilities. Our past experience shows that expansion of capital investments in the hospital sector will result in increased operating costs. Therefore, the exclusion of capital costs from the prospective rates will likely result in a higher rate of inflation in the future.

Fourth, because the proposed prospective payment system applies only to Medicare patients, it could result in discrimination by hospitals. Where patients covered under other insurance systems pay more than what the Medicare program would pay, there would be financial incentives for hospitals to admit all other patients before admitting Medicare recipients. This of course would make hospitals less accessible to the elderly.

I have strong reservations about the likelihood that the Administration's proposal will achieve its goals and strong concerns about its potential adverse impacts. However, on balance I believe the proposed system ought to be adopted because the potential gains may outweigh the potential risks.

Nevertheless, because we lack sufficient knowledge, the proposed program, if effective, can only be so by accident. This cannot provide much assurance for Congress as it seeks to develop plans and sound financing for the Medicare program.

RECOMMENDATION

There is today a basic deficiency in our health care financing system; namely, there is no sustained support for continuous, long-term applied research and evaluation. That explains our lack of sufficient knwledge for policy decisions in health care financing and reimbursement. The Administration has supported several demonstration projects and evaluation studies. But they tend to be short-term in nature and focused on narrowly-specified topics. These projects usually last from one to three years. Although some information has resulted from these short-term research and evaluation studies, they are inadequate in making available to the government the fundamental knowledge on which policy is based. What is needed is support for sustained, long-term applied research and evaluation in health services financing and reimbursement. In my opinion, the most efficient and effective way to do this is to form a partnership between the Government and the universities.

Universities provide a stable environment for continuous and long-term studies. Moreover, universities are able to attract and retain the best qualified and talented people, which no other institutions can match. In addition, some universities, in support of their own educational mission, have already used their own funds to recruit and support these people. If these faculty members could be tapped to devote a significant portion of their time to conduct research into questions that interest the Medicare program, it would benefit our nation while keeping the research cost at a minimum.

In order to provide adequate knowledge and information to answer the questions enumerated earlier in my testimony, the talents of experts from a number of different fields must be assembled, including those of physicians, economists, actuaries, statisticians, financial and organizational specialists. They must work closely together to integrate their expertise to address the problems in health care financing and reimbursement since the problem is multi-faceted.

I recommend that the Congress mandate the establishment of two or three long-term applied research centers on health services financing and reimbursement. Each center should receive core support for at least six years. The amount could be relatively small, around $1.5 million for each center annually. The centers will be charged to develop methods and to discover the fundamental causes for hospital cost inflation and medical cost inflation in general. These centers should be directed to produce results that would have direct relevance to the Medicare program and to public policy. I am confident that such investment in these long-term applied research centers would yield substantial payoff for the Medicare program and for the nation. The investment of less than 5 million dollars per year by the U.S. Government could yield long-term savings amounting to hundreds of millions of dollars each year to the Medicare program.

I can cite an example of the benefits yielded by this type of research. The U.S. Government supported the evaluation of new medical technology to ascertain their cost and effectiveness. One study was for the evaluation of four selected medical procedures. The cost of the study amounted to several hundred thousand dollars. The evaluative results led the Medicare program to decide not to reimburse for these procedures. The estimated savings to the Medicare program, over 10-years, was more than $300 million.

The Congress needs better knowledge and information to legislate wisely. This can be done through such a program as I have recommended. Mandating support for long-term applied research could help to design the best reimbursement policy and financing for the Medicare program. It could be a model for other programs as well.

Chairman Jacobs. Thank you, Doctor.

Mr. Wilson.

STATEMENT OF JOHN WILSON, EXECUTIVE VICE PRESIDENT, REHABILITATION INSTITUTE OF PITTSBURGH, PITTSBURGH, PA., ON BEHALF OF THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES, AMERICAN ACADEMY OF PHYSICAL MEDICINE & REHABILITATION, AMERICAN CONGRESS OF PHYSICAL MEDICINE & REHABILITATION, AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, AND AMERICAN PHYSICAL THERAPY ASSOCIATION

Mr. Wilson. Good morning, Mr. Chairman. I am John Wilson, executive vice president of the Rehabilitation Institute of Pittsburgh.

I am testifying today on behalf of the National Association of Rehabilitation Facilities, the American Academy of Physical Medicine & Rehabilitation, the American Congress of Physical Medicine & Rehabilitation, the American Occupational Therapy Association, and American Physical Therapy Association.

Chairman Jacobs. We will give you an extra minute just because of that.

Mr. Wilson. I appreciate the opportunity to testify on the Department of Health and Human Services hospital prospective system of payment for medicare. I will summarize our statement.

Let me say that while our statement addresses the Department's proposal, we are continuing to analyze it and various alternatives for their impact on rehabilitation. PPS proposes to pay hospitals a stated rate for each type of medicare discharge based on diagnostic related groups, DRG's.

The DRG system is based on short term hospital data and experience. The Department has recognized that application of such methodology to long term care hospitals, which include most free standing rehabilitation hospitals, is inaccurate and unfair.

Imposition of DRG systems based on such data on a percent incident basis would produce serious and inequitable effect on rehabilitation facilities. The Department has therefore proposed to exclude them under the PPS proposal as well as the new cost reimbursement limits published on September 29.

We support that conclusion. However, we have two concerns and recommendations.

First, we recommend that any final proposal exclude rehabilitation units of general acute care hospitals under certain terms and conditions. The same argument and concerns that apply to exclusion of rehabilitation hospitals apply to rehabilitation units.

These are outlined completely in my written statement. They include longer length of stay and greater cost per case for rehabilitation patients.

We suggest the committee exclude rehabilitation units as follows: The provider reimbursement manual, part 1, section 2336, allows for designation of units as subproviders and for the filing of separate cost reports for each such identified element of a hospital. This concept, already established by medicare, offers a way to address the unique needs of rehabilitation units.

Rehabilitation units should be permitted the same exclusion as that for freestanding, long-term hospitals provided that the unit has or obtains a separate subprovider identification number and meets the existing guidelines for inpatient hospital rehabilitation care at section 211 of the medicare hospital manual.

Second, we recommend that any final proposal exclude rehabilitation hospitals as rehabilitation hospitals. In proposing exclusion, HHS has recognized special classes of hospitals by type of malady—psychiatric—or type of patient served—children.

Rehabilitation hospitals are grouped with other long-term health care providers without any commonality other than length of stay. Length of stay is one characteristic by which to differentiate a rehabilitation hospital. Such hospital provides unique services in a unique manner to a specific kind of patient.

We recommend any final proposal provide that a hospital that is accredited by JCAH as a rehabilitation hospital and meets the medicare hospital manual guidelines for inpatient hospital rehabilitation care be excluded.

I will be pleased to answer any questions.

[The prepared statement follows:]

Statement of John Wilson, Executive Vice President, Rehabilitation Institute of Pittsburgh, Pittsburgh, Pa., on Behalf of National Association of Rehabilitation Facilities, American Academy of Physical Medicine and Rehabilitation, American Congress of Physical Medicine and Rehabilitation, American Occupational Therapy Association

SUMMARY

1. The Medicare Prospective Payment System Proposal will pay hospitals on the basis of prospective payment rates which are to be based on a national representative Medicare cost per discharge for each Medicare patient diagnostic related group (DRG).

2. The PPS recognizes that application of the proposed PPS DRG methodology to certain special classes of hospitals would be both inaccurate and unfair. These special classes of hospitals include long term care hospitals which are defined as hospitals whose general length of stay is in excess of 30 days. By definition this includes most free-standing rehabilitation hospitals. The above referenced organizations support this exclusion and HHS's recognition that application of the DRG system is inaccurate and unfair.

The effects of application of the DRG methodology to and change to a per case basis for rehabilitation facilities and rehabilitation units of general acute care facilities is adverse, inequitable and unfair. The case mix cost data upon which DRGs are based is taken only from the cost experience of short term general hospitals.

3. Recommendations:

a. Rehabilitation hospital exclusion.—Other excluded hospitals are recognized in terms of the type of illness they treat (psychiatric) or type of patient (children). Rehabilitation hospitals should be recognized specifically under the exclusion as rehabilitation hospitals. Length of stay is but one criteria by which to differentiate hospitals. Such hospitals provide a unique series of services in a unique manner to a special kind of patient. The final proposal should exclude any hospital accredited by

JCAH as a rehabilitation hospital and that meets the Medicare Hospital Manual guidelines for hospital inpatient rehabilitation care.

b. Rehabilitation unit exclusion.—Rehabilitation units of general hospitals should be excluded in any final proposal. The same arguments that apply to exclusion of free-standing rehabilitation hospitals apply to rehabilitation units. When costs are calculated on a per incident basis or on a per discharge basis, most if not all cases in rehabilitation units will exceed the per DRG level of payments. The DRG system does not reflect the long term rehabilitation cases and therefore the prospective rates for the general hospital which have such units will understate the financial effect of the unit. Also, such units generally have lengths of stay in excess of 30 days.

The final proposal should exclude any rehabilitation unit which obtains a separate subprovider number as currently allowed in the Provider Reimbursement Manual, Part 1, Section 2336 and which meets the existing Medicare Hospital Manual guidelines for inpatient hospital rehabilitation care.

STATEMENT

Mr. Chairman: Good Morning. I am John Wilson, Executive Vice President of the Rehabilitation Institute of Pittsburgh, Pittsburgh, Pennsylvania. I am appearing today on behalf of the National Association of Rehabilitation Facilities (NARF), the American Academy of Physical Medicine and Rehabilitation, the American Congress of Physical Medicine and Rehabilitation and the American Occupational Therapy Association.

NARF is the primary national membership organization of medical and vocational community rehabilitation facilities. Our membership includes some 40 freestanding rehabilitation hospitals and about 80 rehabilitation units of general acute-care hospitals. Most, if not all, of these facilities are Medicare providers. The American Academy, American Congress, American Occupational Therapy Association and the American Physical Therapy Association represent professionals in the field of rehabilitation—the physicians, physical therapists and occupational therapists.

Section 101 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) amended the cost reimbursement limitations on Medicare providers and required the Department of Health and Human Services to develop proposals for legislation which would provide that hospitals, skilled nursing facilities, and, to the extent feasible, other providers will be reimbursed under Medicare on a prospective basis. In response, the Department sent its report titled,"Report to Congress: Hospital Prospective Payment for Medicare" to Congress on December 28, 1982. The purpose of these hearings is to obtain reactions from health care providers and others affected by such a proposal. Our statement is in reaction to that proposal only. We are continuing to analyze it and other alternatives for their effect on rehabilitation facilities.

The proposal is outlined in Chapter III, "The Medicare Prospective Payment System Proposal." In summary, the Prospective Payment System Plan (PPS) proposes to pay hospitals a stated rate for each type of Medicare discharge. The rates are to be based on a "national representative Medicare cost per discharge for each Medicare patient Diagnosis Related Group (DRG)."

We have examined the PPS proposal and are pleased to note that it will exclude long term care hospitals which include most rehabilitation hospitals (Page 50). The Health Care Financing Administration has recognized that application of a DRG based methodology to these hospitals is "inaccurate and unfair." We has pointed this fact out to HCFA when it was developing the regulations to implement to new cost reimbursement limitations and PPS. As stated in a September 2 letter to Carolyne Davis, Administrator of the Health Care Financing Administration, the DRG methodology and data are taken from the experience of short term hospitals which have an average length of stay of 7 to 11 days. Rehabilitation hospitals and units generally experience lengths of stay of over 30 days, and, those concentrating on very serious diagnoses, such as spinal cord and brain injuries, have much longer lengths of stay.

In the past, rehabilitations facilities have experienced no unusual problems with 223 limits since their per diem costs have been in line with other hospitals. However, the shift from a per-diem limit to a per-incident limit would also be inequitable.

Also, there would be incentive for acute care hospitals to discharge patients earlier. For rehabilitation hospitals this would mean patients are likely to be transferred from acute care to rehabilitation facilities at an earlier state of treatment necessitating longer stay in the rehabilitation hospital.

The interim final regulations published on September 30 exempted long term care hospitals from the new limitations. Long term care hospitals are defined by HCFA as those having a length of stay generally in excess of 30 days. Generally, they have a provider number in which the third digit is a "2", "4" or "7". This exemption includes most freestanding rehabilitation hospitals because they have a length of stay generally in excess of 30 days.

While we support the exclusion from the PPS proposal of long term care hospitals, the proposal does, however, raise two concerns. They are:

1. Rehabilitation hospital exclusion

In proposing the specific exclusions, HHS has recognized most of the special classes of hospitals by the type of malady (psychiatric) or type of patient (children) served. Rehabilitation hospitals are grouped with other long term care providers without any commonality other than their lengths of stay. Rehabilitation hospitals should be recognized under the exclusion specifically as rehabilitation hospitals. Such hospitals provide a unique series of services in a unique manner to a specific kind of patient. Length of stay is but one characteristic by which to differentiate hospitals. We recommend that any final proposal provide that a hospital that is accredited by JCAH as a rehabilitation hospital and that meets the Medicare Hospital Manual guidelines for hospital inpatient rehabilitation care be excluded from the prospective payment proposal.

2. Exclusion of rehabilitation units

The considerations which justify exemption of free-standing long-term hospitals including rehabilitation hospitals are equally valid for rehabilitation units of general hospitals. As noted above, NARF represents approximately 80 rehabilitation units.

The lengths of stay and case-mixes of such units are substantially the same as those of free-standing rehabilitation hospitals. Almost all such units have lengths of stay in the range of 30 days. As in the case of free-standing hospitals, the cost of rehabilitation units are in line with general hospital costs when examined on a per diem basis; however, because of the longer lengths of stay this picture changes radically when costs are calculated on a per incident basis or on a per discharge basis as they are proposed to be under the prospective payment system. Accordingly, most, if not all, cases in such units will exceed the per DRG level of payment. Also, as in the case with free-standing facilities the DRG system does not reflect the long-term rehabilitation cases and therefore the case mix adjustment figures for the general hospitals in which such units are located will understate the financial effect of rehabilitation units.

We suggest the Committee exempt rehabilitation units. The unique characteristics and cost experience of rehabilitation units (and others with similar characteristics) are currently recognized under Medicare. The Provider Reimbursement Manual at Part 1, Section 2336 allows for designation of units as subproviders and for the filing of separate cost reports for each such identified element of a hospital.

This concept, already established by Medicare to deal with cost centers with widely varying cost experience, offers an appropriate means for addressing the unique position of rehabilitation units. Rehabilitation units should be permitted the same exemption as that of free-standing long-term hospitals provided that the unit has or obtains a separate subprovider identification number and meets the existing guidelines for inpatient rehabilitation care at Section 211 of the Medicare Hospital Manual.

This approach is consistent with the methodology used to construct the rates proposed by the prospective system. It is our understanding that the costs of units of hospitals with subprovider identification numbers are not included in the calculation of per incident limits. This mechanism is one way by which to exempt such units and is a logical extension of the policy of excluding their costs in calculation of the new DRG payment levels.

I would be pleased to answer any questions.

Chairman JACOBS. Thank you, Mr. Wilson, very much.

Mr. Hall.

Dr. DUVAL. My name is Merlin DuVal. I am president of the Associated Hospital Systems.

Chairman JACOBS. Is that the order?

Dr. DUVAL. It was not, but you called me, so I responded.

Chairman JACOBS. I called Mr. Hall. Let me call Mr. Turner.

STATEMENT OF E. WINSLOW TURNER, MEMBER, GOVERNMENT RELATIONS COMMITTEE, NATIONAL MULTIPLE SCLEROSIS SOCIETY

Mr. TURNER. Mr. Chairman, I am E. Winslow Turner, I am a member of the Government Relations Committee of the National Multiple Sclerosis Society. Formerly I was committee counsel in the Senate. I am now retired and a practicing attorney in Washington, D.C.

The primary question which concerns the society is how the prospective payment system will impact on the quality of health care services to medicare beneficiaries with multiple sclerosis. Now, these beneficiaries with MS are not just our older citizens, but they are young, they are the middle aged and those that are covered by social security disability insurance.

So, we have a somewhat different population from those that were being described today by previous witnesses.

We have conferred with a representative sample of neurologists who direct programs of quality care for individuals with MS on both an in patient and out patient basis.

Our primary concern with the proposed system of establishing a diagnostic related group is that it will create substantial disincentives for those hospitals which are presently best capable of providing appropriate care for individuals with multiple sclerosis and in addition totally discourage future improvement in the much needed service mix in other hospitals.

In the case of multiple sclerosis and many other relatively uncommon disorders, the average in-hospital MS treatment program does not necessarily represent an appropriate quality of health care.

With respect to MS, for the programs which are generally considered good, the cost is significantly more than the average cost. Thus a DRG prospective payment to one hospital whose key personnel are unable to provide comprehensive health care for MS patients may be sufficient payment for those limited aspects of care the hospital is able to provide. But the same prospective payment may be wholly inadequate for another hospital with a specialized program of care for persons with our disease.

One comprehensive care hospital is the Fairview Deaconess Hospital in Minneapolis where a MS multidisciplinary team is headed by Dr. Randall T. Shapiro.

It is very clear that the average hospitalization, about 1 week, involving neurological services, bowel and bladder management, drug therapy, occupational and physical therapy, psycho social services and all requisite nursing services cannot be supported at the average cost of $1,899, which is the figure listed for the "DRG No. 13: Multiple Sclerosis and Cerebellar Ataxia" in the Health Care Finance Administration's printout enclosed as appendix I of the DHHS report to the Congress on hospital prospective payment for medicare, December 1982—the blue book.

By the same token, the highly respected MS program of comprehensive health care at Albert Einstein College of Medicine [AECM] in the Bronx, directed by Dr. Scheinberg, would not be possible for MS medicare patients under the prospective payment system.

AECM is an example of a tertiary university research and training institute in which complex MS problems are treated in hospital and studies on cost savings by outpatient therapy and day-hospital programs are being conducted. In a 1-year period 1980–81 173 patients were treated in-hospital for 3,486 days, ranging from 2 to 80 days for an average of 20 days.

The point is that with the combination of factors regarding the disease itself, the variable capabilities of health care facilities and the current limits of medical knowledge about optimal treatment for many symptoms of the disease, the prospective payment system currently recommended will fail to support adequately the hospitals which already are providing high quality health care for persons with MS and will discourage improvement in capability of those hospitals moving to fill that need.

In considering ways to address this problem, we have thought of several possible avenues of approach.

One immediate way to cope with the problem is to include DRG's of relatively rare incidence which require very specialized skill in the same category as the other types of care which the Secretary proposes would still be reimbursed on the basis of cost because adequate study has not been done.

Another avenue might be to provide for pass through reimbursement for quality care programs in the same general way the outlier cases would be covered.

Another approach might be some structure by which experts in the treatment of MS are asked to prepare a range of appropriate therapeutic treatment models which would be used to adjust a prospective payment schedule from data based on historical average to a reasonable appropriate quality of comprehensive care.

We are prepared to arrange access for the subcommittee and the administration to persons who are experts in MS health care, as it is desired.

Mr. Chairman, the National Multiple Sclerosis Society is strongly supportive of the Federal, State and private efforts to contain the health care cost increases which will help reduce the potential of impact. Systems that will tend to make the health care provider system more efficient may thereby also reduce the potential of enactment of further cost saving and copayment proposals which would place a greater burden on our people.

Thank you very much for the opportunity to testify today.

STATEMENT OF THE NATIONAL MULTIPLE SCLEROSIS SOCIETY

Mr. Chairman and Members of the Committee, the National Multiple Sclerosis Society is pleased to have the opportunity to present it's perspectives on the proposed Medicare Prospective Payment System. The primary question which we have attempted to investigate is how implementation of the prospective payment system would impact on the quality of health care services to Medicare beneficiaries with multiple sclerosis. Our tentative conclusions also have implications for many other individuals who suffer from less common diseases or disorders for which there is, as yet, markedly limited specific therapy.

DRG PROSPECTIVE PAYMENT IMPACT ON QUALITY OF CARE

We have conferred with a representative sample of neurologists who direct programs of quality care for individuals with multiple sclerosis on an in-patient and out-patient basis. Some significant data on costs related to in-hospital programs for multiple sclerosis has been examined.

Our primary concern with the proposed system of establishing a diagnostic related group (DRG) encompassing multiple sclerosis and assigning a specific cost for prospective payment is that it is likely to incorporate substantial disincentives for those hospitals which are presently most capable of providing appropriate care for individuals with multiple sclerosis and in addition, totally discourage future improvement in the much needed service mix in other hospitals. The system of determining the prospective payment for a diagnostic related grouping is based on a sample of the historical cost data covering all types of hospitals. But, in the case of multiple sclerosis and many other relatively uncommon disorders, the "average" in-hospital MS treatment program does not necessarily represent an appropriate quality of health care.

The wide range in age of affected persons, 15 years through old age (85 percent normal life expectancy), plus the tremendous variation in clinical severity of the disease from one person to another and within the same person over the years, provides problems of paying on the basis of one DRG rate for all therapy. It must be emphasized that while MS afflicts persons over a wide span of years, the onset and socioeconomic impact to productivity in early and middle adulthood demands that substantial investment in treatment be made widely available.

With respect to MS, programs which are generally considered good, cost significantly more than the "average" cost. Thus, a DRG prospective payment to one hospital whose key personnel are unable to provide comprehensive health care for MS patients may be sufficient payment for those limited aspects of care the hospital is able to provide. But the same prospective payment may be wholly inadequate for another hospital with a specialized program of care for persons with MS. The result is incentives to those providing less than adequate quality care and disincentives to those providing an optimal quality of care.

Our views on the diverse quality of care for persons with MS by hospitals is not intended to be an indictment of hospitals. We are observing significant improvement in the capability of hospitals to provide the appropriate mix of medical, surgical, rehabilitative and psychological services. However this capability is not yet implemented to a degree that would be reflected in the retorspective analysis defining DRG costs. Such comprehensive services have been developed in numerous hospitals and from those experiences it will be possible to derive true DRG estimates.

One such hospital is the Fairview-Deaconess Hospital in Minneapolis where an MS multi-disciplinary team is headed by Dr. Randall T. Shapiro. Extensive data has been collected which has not yet been analyzed with respect to costs, but it is very clear that the average hospitalization (about one week) involving neurological services, bowel and bladder management, drug therapy, occupational and physical therapy, psycho-social services, and all requisite nursing services cannot be supported at an average cost of $1,899.38—which is the figure listed for "DRG Number 13: Multiple Sclerosis and Cerebellar Ataxia" in the Health Care Finance Administration printout enclosed as Appendix I of the DHHS Report to the Congress on Hospital Prospective Payment for Medicare—December 1982 (The Blue Book).

The highly respected MS program of comprehensive health care at Albert Einstein College of Medicine (AECM) in the Bronx, directed by Dr. Labe Scheinberg, would not be possible for MS Medicare patients under the prospective payment system. AECM is an example of a tertiary, university research and teaching institution in which complex MS problems are treated in-hospital and in addition, studies on cost-savings by out-patient therapy and day-hospital programs are being conducted. In a one year period 1980–81, 173 patients were treated in-hospital for 3,486 days, ranging from 2 to 80 days for an average of 20 days. On the basis of AECM reimbursement rate of approximately $500 per diem, costs averaged 20×500=$10,000. While AECM is organized to provide a mix of comprehensive services, the high cost of such centers is also based on complex differential diagnoses, treatment of intractable urinary and pulminary infections, surgical interventions such as tenotomies, and spinal cord sections for incurable spastic muscle contracture or pain and recurrent decubitus ulcers. It bears emphasis that with the advancing technical competence of hospitals and medical professionals, an increasing number of hospitals will become capable of such complex therapies.

In many community hospitals MS patients are admitted primarily for the purpose of administering and monitoring the clinical response to intravenous ACTH (Adrenocorticotrophic Hormone). Provided sufficient reimbursement or prospective payments were made for this on an out-patient basis, some hospitalizations could be avoided. This type of relatively inexpensive in-patient care is quite different from the more expensive treatment of complications and secondary symptoms such as bladder infections, etc., alluded to above. It is also quite distinct from the programs of in-hospital and out-patient coordinated, multispecialty comprehensive care which our studies indicate are both cost effective in comparison to other models of uncoordinated and framented interventions which do not provide holistic management of the patient and family.

Despite the efforts to determine how costs could be decreased by providing many diagnostic studies and treatments on an out-patient basis, patients that travel long distances from sparcely populated areas, as is the case with Dr. Shapiro's service at Fairview-Deaconess Hospital, may require hospitalization in order to receive the basic services. Alternative low cost hospital-adjunct motels would help keep DRG rates lower. In contrast the urban metropolitan service at Albert Einstein Center in the Bronx is able to handle a larger percentage of relatively high cost patients on an out-patient basis thus preserving the in-hospital services for much more complex high cost problems.

The point is that with the combination of factors regarding the disease itself, the variable capabilities of health care facilities, and the current limits of medical knowledge about optimal and predictable treatment for many symptoms of the disease, the prospective payment system currently recommended will fail to support adequately the hospitals which already are providing high quality health care for persons with multiple sclerosis and totally discourage improvement in capability of those hospitals moving to fill this need.

In considering ways to address this problem, we have thought of several possible avenues of approach. One immediate way to cope with the problem is to include DRG's or relatively rare instance which require very specialized skill in the same category as the other types of care which the Secretary proposes would still be reimbursed on the basis of costs because adequate study has not been done (e.g. psychiatric, pediatric, etc.). Another avenue might be to provide for pass through reimbursement for quality care programs in the same general way the "outlier" cases would be covered. Yet, another approach might be some structure by which experts in the treatment of MS are asked to prepare a range of appropriate therapeutic treatment models which would be used to adjust a prospective payment schedule from the data based on historical "average" to a reasonable appropriate quality of comprehensive care. We are prepared to arrange access for the Subcommittee and the Administration to persons who are "experts" in MS health care, as it is desired.

PAYMENTS FOR OBSERVATIONS ON THE EFFECTIVENESS OF NEW THERAPIES

In the continuing search for specific therapies to halt or reverse the serious outlook in MS, numerous trials of new drugs and procedures are being conducted or planned. Because such observations are most effectively carried out in clinical teaching centers, it is recommended that DRG prospective payment adjustments include such a categorical approach. Specifically, it is recommended that with regard to treatments which have already undergone initial testing and been reported in respected medical journals, reimburement should permit extension of such observations on the basis of approval by the National Institutes of Health in consultation with the National Multiple Sclerosis Society. Such work should be limited to academic medical centers where monitoring of the clinical observations can be guaranteed. Examples of these therapies are interferon, plasmapheresis, hyperbaric oxygen, immunosuppressive drugs, etc. In this regard, we are assuming that the construction of the "lump sum" indirect costs payment to teaching hospitals will include the costs of clinical tests and procedures that historically have been the basis of new directions for therapy.

GENERAL PERSPECTIVE

The National Multiple Sclerosis Society is strongly supportive of Federal, State and private efforts to contain the health care cost increases. We believe that physicians and other health care providers control most of the health care cost decisions for persons with MS. Therefore, proposals aimed at developing a more efficient health care system such as prospective reimbursement have objectives which we share.

Moreover, since copayments and cost sharing are already a substantial reality and since some appropriate medical therapies and equipment are not currently reimbursed, persons with multiple sclerosis and their families are often already stretched to their financial limit. Systems that will tend to make the health care provider system more efficient may thereby also reduce the potential of enactment of further cost sharing and copayment proposals which would place an even greater burden on our people.

Health care cost containment, through whatever mechanism, as it impacts upon those disabled by multiple sclerosis and many other diseases or disorders ought not be considered by the Congress as a health costs issue isolated from other budgetary impacts. Even if quality medical care costs more, it often holds the promise of not only improving the quality of life for individuals treated but of reducing the overall federal budget because the other federal expenditures such as income maintenance (e.g. SSDI) and long term care may be reduced as a result of effective health care.

We believe we have highlighted a problem with the proposed "Prospective Payment for Medicare" which needs to be examined and resolved prior to a time when a new system of prospective payment would apply to specialized MS treatment programs and MS comprehensive care centers. We are ready to work with representatives of the Subcommittee and others in an effort to provide the type of detailed information which is needed to construct a reasonable solution.

Chairman Jacobs. Dr. DuVal, I had said Mr. Hall. That is where the confusion was.

Please proceed.

STATEMENT OF MERLIN K. DuVAL, M.D., PRESIDENT, ASSOCIATED HOSPITAL SYSTEMS

Dr. DuVal. My apologies.

My name is Merlin K. DuVal. I am president and chief executive officer of Associated Hospital Systems which own and manage or otherwise provide services to approximately 475 hospitals representing 50,000 beds.

We hold the position that we have paid the price for retrospective reimbursement and its expansionist incentive.

As for congressional alternatives, there are probably only two. One is to set prices prospectively and the other is to force some form of direct negotiation between payers and providers over price.

Like Mr. Gephardt, Mr. Gradison, Secretary Schweiker and others, we think the latter is the answer rather than the former.

We have submitted written testimony that will speak specifically to the issue of how to force direct negotiations between payers and providers over price. We have a fully worked out capitation proposal and we will bring that to your attention very shortly.

In the meantime, you are today considering prospective pricing based on diagnostic related groups. We think this is a reasonable start. We also consider it, however, a weak alternative principally because the accuracy of the data, as has been brought up this morning, is seriously to be questioned. Further, it invites cost shifting. It invites nonassignment, it creates incentives to hospitalize, it will substantially increase administrative costs and it will strangle the introduction of new technology. But if you choose to proceed rather than wait on an acceptable capitation or voucher proposal, then we would ask you to consider the following modifications of the proposal that lies in front you.

First, we urge strongly that you avoid, at all costs, setting national DRG average cost per case. This has no more merit in our judgment than to determine that the average cost of an airplane, submarine or missile or a house or automobile can be, in effect, used in the marketplace. Rather, we would ask that you bring the average cost per case down to a regional basis if not to an institutional basis.

Second, we would petition that the annual readjustment of the DRG value be done outside of the Department of HHS by an independent agency.

Third, we think it is essential that you provide for both administrative and judicial review.

Fourth, we would exclude for the moment until the data are more trustworthy the very highly specialized hospitals. The case has been made exceptionally well by some of my colleagues this morning.

Fifth, we would urge you to permit waivers for States and/or health care systems that bring in promising experiments. We believe the answer will be in such experiments and we hope you will consider waivers to permit them.

The essence of my verbal statement this morning is that your problem is a difficult one. We respect that. We think your proposed solution is probably not going to do the job, but we are prepared to work with you to try to make it work.

We simply hope you will take into consideration some of the improvements that we think are essential and that we would urge you to consider.

[The prepared statement follows:]

Statement of the Associated Hospital Systems

Mr. Chairman, I am Merlin K. DuVal, M.D., President and Chief Executive Officer of the Associated Hospital Systems, an association of eleven of the nation's largest non-profit, multi-institutional health care systems. The members of this Association own, operate, manage or provide contract services to over 475 acute acre nonprofit hospitals. We very much appreciate this opportunity to testify on Medicare prospective payment plans and are eager to participate constructively in this important health policy debate.

Our member systems strongly support reform of the present Medicare retrospective cost-based payment system, which has outlived its usefulness. We are anxious to move toward a payment system which is prospective, which has incentives for efficiency rather than arbitrary caps, and which is based on prices. In an ideal world this would take the form of a per capita payment because it allows greater choice by beneficiaries and more flexibility in the negotiation of provider payment plans. The objectives of such reform should be to promote incentives for efficient and economical provision of hospital services, to strengthen market forces in the hospital sector, to encourage cost consciousness on the part of patients and providers and to reduce the need for government regulation.

Recognizing that this Subcommittee is focusing its attention today on the DRG-based plan, we want to share with you some of our concerns centered on this proposal. Since it is possible that this plan may advance in Congress, we also want to call your attention to several modifications which would in our view make the proposal more equitable and reasonable. We think the plan in its present form puts hospitals at total risk for operating within payment constraints while significant decisions by other providers and patients are clearly outside the control of hospitals. This is not only unfair, but it is an untenable situation. In this regard, we support the testimony of the American Hospital Association which identifies many of the recommendations we will offer to you.

At the outset, Mr. Chairman, we want to express our reservations about the validity of the particular DRG-based plan developed by the Department. A great many assumptions were used in the construction of this plan, many of which have not been validated. More particularly, the Department's plan presumes that errors or omissions in the recording of clinical data are not likely to produce significant distortions in the calculation of national Medicare rates. In fact, we believe the accuracy of the data is questionable, that the sample of bills from which the diagnostic data is obtained may not be representative of a hospital's Medicare experience and that these problems can indeed produce very significant distortions in national rates. Further, the assumption in the Department's plan that the mix of cases within each of Medicare's proposed national DRG categories approximates the mix of cases in each of an individual hospital's DRG categories is far from verified, and constitutes a potential source of grave errors and inequities in fee payment rates.

Apart from these questions about the reliability of existing data, we are worried about the incentives rewarding low cost, short-term admissions. While there does not appear to be any evidence supporting significant changes in admission rates in New Jersey during their experiment with DRG-based payment, we are concerned about a payment plan which could lead to hospitalization for cases now routinely treated on an ambulatory basis. At the same time we wish to note the potential created by the large variation in the cost of cases within some DRG's for some institutions to screen elective admissions for the purpose of referring more complicated and potentially costly cases to other institutions. Overall, the potential for manipulation of admissions policies must be examined and policy mechanisms explored that assure the appropriateness of admissions and referrals.

In a related area, we want to call your attention to the potential compromise of the objectivity and independence of the hospital medical records system that a DRG-based payment plan may encourage. The matter of so-called "DRG-creep" is, in our view, the possible consequence of basing payment on diagnostic information recorded before the program became effective. Where the selection of recording primary and secondary diagnoses can significantly alter payment, the potential for changing past practices in coding medical records exists.

Another concern to our member systems concerns the new administrative costs associated with a DRG-based payment system at the institutional level. We understand that the integration of clinical and financial data systems will be essential to the effective management of a hospital. The expenses of installing and operating such systems are considerable and we do not see any allowance for these expenses in the calculation of DRG rates.

Finally, we assume that the present Medicare policy of responsibility for the payment of beneficiary bad debts will be continued under the DRG plan. We do not find, however, any discussion of this issue in the Department's report to Congress, but we presume that cost sharing would be paid separately by Medicare in the event beneficiaries did not otherwise meet these obligations. This payment could be handled in a manner similar to the pass-through of education and capital costs.

We noted earlier in our statement that we would like to offer some constructive recommendations for the improvement of the Department's plan even though our preference is for an altogether different approach to the reform of Medicare. We also believe that considerable harm will be inflicted on hospitals and Medicare beneficiaries if the present payment policies under TEFRA are continued. We have five specific recommendations which we believe are necessary to improve the present plan.

First, in establishing the rate initially for each DRG, we think it necessary to take account of the practices in the health services market in which a hospital is located. The Department's plan uses Medicare's national average cost experience, adjusted for area wage rates, as the method of setting DRG rates for each hospital. We believe that a regional cost base would be more appropriate as it would take into account other regional cost variances in addition to wages, and avoid the harmful result flowing from excessive over or under payments.

Second, we want to recommend the appointment of an independent panel for the purpose of forecasting the amount of the annual adjustment of DRG rates. The Department's plan reserves this function for the Secretary and leaves to his or her discretion the method for calculating an inflation adjustment and adjustments related to improvements in service or productivity. As an example of what we have in mind we point to the panel of economists appointed in New York for this purpose. Furthermore, we believe that the statute should prescribe the components in detail which should be a part of the method for determining an annual adjustment to Medicare payment rates.

As an aside we would also like to point out our objection to the Department's plan where it fails to require any consideration of the effects of technology and growth in services when the base rates are trended forward to their first year of use. If an allowance for these factors is not provided, the level of the initial rate will be well below the costs incurred to provide the care. Our anxiety over this issue is heightened by the Department's recommendation to delete the one percent technology allowance under the TEFRA target rate formula in fiscal year 1984.

Third, we support the exclusion from the Department's plan of specialized institutions such as pediatric and psychiatric hospitals and long-term care facilities. We recommend that this exclusion be broadened to include other types of specialty hospitals whose services and mix of patients are markedly different from the typical acute care hospitals. These national medical centers, such as cancer hospitals, should be handled separately by Medicare.

Fourth, in our review of the Department's plan we were disturbed to find very little detail about the opportunities for exceptions and adjustments or about the administrative remedies that would be available. We are very much opposed to the proscription of judicial review of payment disputes and recommend that this provision be dropped. Further, we think any legislative proposal embodying the DRG plan should include a description of the grounds for exceptions and special adjustments to the rates along with a description of the administrative remedies open to hospitals.

Fifth, we would like to recommend that any legislation in this area permit the opportunity for continued experimentation with promising alternative payment policies under Medicare. We do not believe the DRG approach has proved itself as the desired payment system, and neither do we believe that enough is known about other payment methodologies. It should be possible for states or systems of hospitals to be granted waivers from the Medicare payment system when they have designed promising experiments. For example, we believe it should be possible for systems of hospitals to negotiate a risk contract with Medicare and receive a per capita payment for the provision of covered services similar to the arrangements now permitted for HMO's and competitive medical plans.

Over the past year our Association has devoted considerable time to the exploration of a number of alternative payment system policies which might best meet these objectives. At the same time we have watched closely the development and enactment of additional cost constraints on the present system for reimbursing hospitals for their services to Medicare beneficiaries. In particular we are convinced that the reimbursement changes in last year's TEFRA will, if continued, do serious damage to the financial viability of many of our nation's hospitals. Further, our review of the Department's DRG-based payment plan gives rise to a number of concerns which we will describe in some detail later.

Based on our discussions to this point, we believe that the Medicare program should begin moving toward the goal of providing its beneficiaries with the health plan choices available in the private sector. There is a vigorous and increasingly competitive private market for both traditional health insurance plans and for a variety of emerging alternative delivery systems which, for the most part, are not now available to the beneficiaries of Medicare. In short, we envision a new role for Medicare as a financer of the health plan choices made by beneficiaries in the private market. This role would eliminate much of the direct role of the government as the payer for services and as the regulator of the hospital sector—roles which we believe have not been played effectively.

Our intent is to recommend a certificate plan for Medicare under which the program would annually provide for the purchase of qualified private health plans. The method for determining the initial value of the certificate and for its annual adjustment would be detailed in the statute. In our experience we believe it would be possible to maintain access for Medicare beneficiaries to the present level of benefits while at the same time reducing the uncontrolled financial risk to government that characterizes the present program. We realize, Mr. Chairman, that this is a more controversial change than either TEFRA or the DRG plan of the Department, but we feel that only a fundamental change can resolve the problems ahead for Medicare.

We are aware of the estimates furnished to you concerning the fiscal crisis for Medicare which is rapidly approaching. One consequence of this funding problem could be a precipitous cut in benefits and a loss of access to quality services on the part of Medicare beneficiaries. We share your concern that this outcome not occur. This is in large part the motivation for our development of a plan to protect the integrity of the program and to stimulate efficiency and economy in the provision of health services.

While our certificate plan is not fully developed at this point, we can describe some of the advantages of this type of plan. First, it would rely on the competitive forces of the market to produce economical health plans for the elderly. The purchasing power of the Medicare program would create strong incentives for the development of cost-effective delivery systems in order to be competitive in the Medicare market. Second, it would eliminate the need to construct and operate a nationwide hospital payment system for Medicare. Payments to providers of services would be negotiated by the plans and the providers operating under the discipline of the constraint imposed by the value of the certificate. Finally, it would leave to government the important responsibility of assuring fair competition, consumer protection, and the level of health coverage it is willing to finance.

We supported the expansion of Medicare last year to permit prospective payment of HMO's when selected by Medicare beneficiaries. This provision should be expanded in accordance with a plan to gradually move toward a certificate system as outlined above. It is our strong belief that this approach to Medicare reform is preferable to either the payment changes in FEFRA or the proposed DRG-based payment plan recently submitted by the Department of Health and Human Services.

Mr. Chairman, we have intended to provide you and the Subcommittee with our views about the future design of the Medicare payment system. We think a certificate approach should be developed now and scheduled for implementation when the present special payment provisions of TEFRA expire. We are eager to work with you toward that objective. We believe such a system is our best hope in the long run of meeting the cost-containment requirements of Medicare, and removing government from its hopeless snarl of regulatory efforts. We see TEFRA and DRG's as further "ensnarlments," and do not think they will work.

At the same time we know you are seriously considering the Department's DRG-based payment plan. In our opinion this plan raises a number of concerns, some of which we pointed out to you, and we have made several specific recommendations which we feel are necessary to make that plan equitable and reasonable. Should you favor this plan, we hope you will consider our proposals and that you will continue the opportunity for further study and experimentation with alternative payment policies.

In the final analysis all of us must share equitably in the risks of a new payment policy. Providers, beneficiaries, and payers must all bear some risk for the decisions that result in the provision of health services. We hope you will agree with us that the proposal before you today does not distribute the risks and responsibilities of our health care delivery system fairly.

Again, thank you for this opportunity to testify. We would be pleased to answer any questions you or other members of the Subcommittee may have.

Chairman JACOBS. Thank you, Doctor.

Mr. Duncan.

Mr. DUNCAN. I have no questions. Thank you, Mr. Chairman.

Chairman JACOBS. Doctor, I might say that the initial recommendation proposed by the administration does not even so much as suggest regional data. We are led to believe that the administration is entirely adverse to such an approach. I don't think it is in the cards that the data is going to be hospital by hospital. That may be asking a little too much.

I should not be surprised, I will say in all candor, that the administration were not unfriendly to the idea of regional data.

Dr. DUVAL. That is encouraging. Thank you, Mr. Chairman.

Chairman JACOBS. I thank the panel for its testimony. I thank you on behalf of the committee, the Congress and the people.

The National Association of Public Hospitals, Larry S. Gage.

Also on this panel the Gray Panthers, Frances Klafter, who is the chair of the National Health Task Force.

Mr. Gage.

STATEMENT OF LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Mr. GAGE. Thank you very much, Mr. Chairman. I will be brief. I have submitted a prepared statement for the record.

Basically I am appearing today on behalf of 39 public hospitals or hospital systems around the country in our largest cities.

The simple fact I want to establish about public hospitals in this situation is that they are substantially different from the entire rest of the health care system and the reason you can afford the luxury of no longer talking about national health insurance in Congress and in Washington is because of the existence of these hospitals.

We make a number of points and have for 2 years about the importance of this system, the fact that they continue to serve all patients with a wide range of other services they provide, the fact their inflation level over the last 5 years has been 5 percentage points lower than the hospital industry.

The basic points we feel we have to make today surrounding new changes in medicare is that we are partners with you in governmental provision of services and we are de facto the institutional safety net.

We also have several comments in our prepared testimony regarding the prospective payment system and the administration's proposal. We believe there are serious flaws in that prosposal.

We also realize it may be on a fast trade and therefore we will try to make our criticisms as detailed as possible and perhaps suggest amendment.

We probably alone in the hospital industry believe it should apply to all payers and not medicare even if it is just a pipe dream.

We believe the experience of the administration with regard to the TEFRA medicare limits you passed last year in which you required an adjustment for hospitals serving large numbers of poor people and they refused to implement one, indicates you have to pay careful attention to that aspect in the course of your legislating this year.

We believe there are serious flaws in the DRG system. We don't believe the DRG takes into account the relative severity of sickness.

We do believe that public hospital patients are sicker. We will try to provide data to support that. We don't have the luxury of elective surgery. The demand for most public hospital services is a demand for emergency room service and in some cases 100 percent of admissions to public hospitals in some cities come through emergency rooms.

Nevertheless, we think DRG's will favor surgery in lieu of out patient services and we think that is a significant flaw in the system. We think there will be unnecessary surgery performed in a lot of private hospitals as a result of nationwide DRG systems.

We believe that the definition of outliers will substantially impact all urban hospitals including public hospitals. We think public hospitals will have an additional impact because when public hospitals have outliers, they are outliers who have no method of payment and a $100,000 bill for them is much heavier than for a medicare patient.

We believe there is likely to be DRG induced dumping, DRG creep, discouragement of out patient department services.

We think all of these things which the administration claims it is going to monitor, they are going to be 2 years behind and meanwhile it is the public hospital system that will be absorbing patients who are transferred because they are too sick within a particular DRG.

Finally, we simply urge you to take into account, as I said, the failure of the administration to provide any recognition of the need of hospitals to serve substantial numbers of poor people.

I would like to close by making a pitch that I have been making for several months on behalf of public hospitals who are taking much of the burden of the current unemployment crisis.

Originally we couldn't find unemployed people in our out patient departments and emergency rooms, but they are turning up now. It turns out many have postponed care for a long time until they are sicker. They are uninsured so they become charity patients. They are being transferred to our institution from private hospitals.

We are seeing immeasureable increases in charity patients. These patients are whiter, more solidly middle class. They own small homes or cars. They are ineligible for medicaid. We ask Congress in the course of job legislation or in the course of this bill to set aside something in direct support for those institutions that care for these people, at least during the current crisis.

[The prepared statement follows:]

STATEMENT OF LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Mr. Chairman, members of the subcommittee, I am Larry S. Gage, President of the National Association of Public Hospitals. NAPH represents public hospitals or hospital system in 39 of our nation's largest cities, counties and SMSAs. On their behalf, I thank you for this opportunity to testify today on the subject of prospective payment systems and the Administration's DRG-based proposal.

There are three parts to my prepared statement this morning, Mr. Chairman.

First, I will briefly summarize the overall situation of urban public hospitals in America today in the face of Federal, State and local budget crises on the one hand, and increased demand for public hospital services due to economic recession, on the other;

Second, I will address a number of specific public hospital concerns with the Administration's prospective payment proposal; and

Third, I would like to discuss briefly a significant current problem for public hospitals—the tremendous number of poor Americans who have inadequate or no health insurance coverage today—and ask this Committee at least to help remedy one small part of that problem by adopting a program this year to provide health care for unemployed Americans.

THE SITUATION OF URBAN PUBLIC HOSPITALS TODAY

There is little debate in America today of the kind of proposals we used to call "national health insurance". But we believe there is an excellent reason why the Congress and the Administration can afford the luxury of ignoring the huge gaps in our current health insurance system. It is because we already have "de facto" national health insurance in many of our cities today—in the form of our nation's public hospitals.

We believe this is an important fact for you to bear in mind as you consider proposals to "reform" Medicare or other isolated pieces of the health reimbursement system. Consider the following key facts about our nation's urban public hospitals today:

Public hospitals continue to take all patients—regardless of ability to pay. Data being collected for a new American Hospital Association/Urban Institute study shows that just 15 of the largest public hospitals in the country provided $597 million in non-Medicaid charity care in 1980 alone.

Wholesale reductions in medicaid eligibility, benefits and provider payment levels in many States have caused serious additional strain on pubic hospitals' resources. In particular, private hospital dumping of Medicaid and other indigent patients is clearly and measurably on the rise.

The nonmedicaid uninsured caseload of public hospitals has also substantially increased. In addition to reductions in Medicaid eligibility, this problem is exacerbated by increased unemployment, and inadequate funding for special populations such as illegal aliens and refugees.

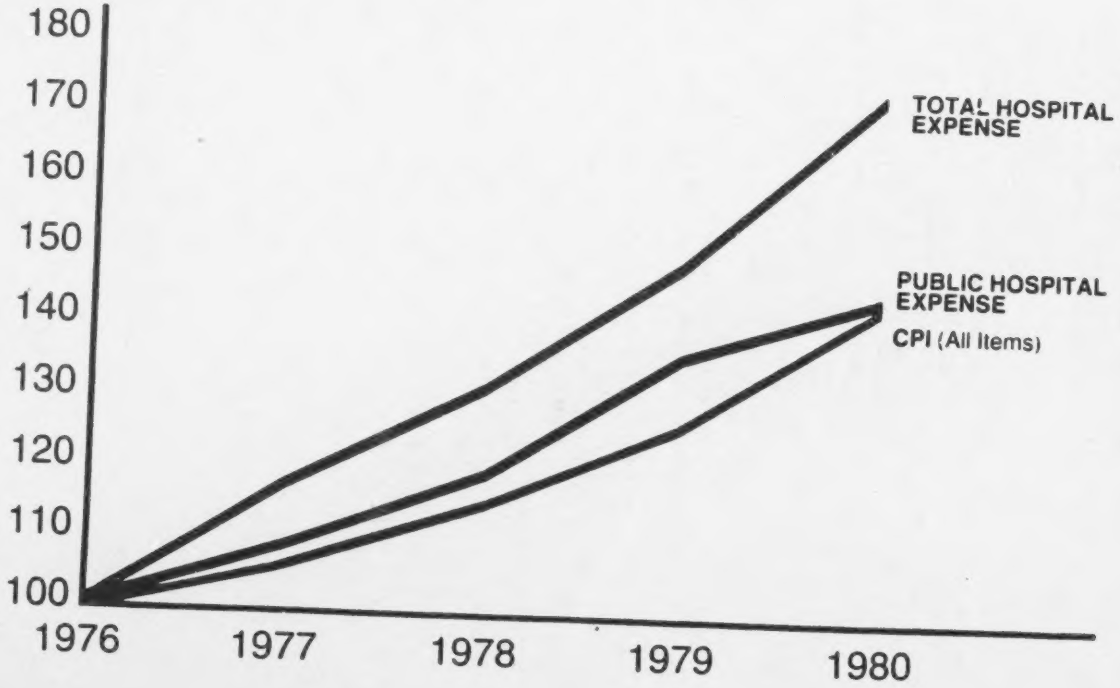
Public hospital budgets have inflated far less rapidly in recent years than the rest of the hospital industry. New NAPH data show an average annual inflation rate for public hospital budgets of just 9.8 percent per year between 1976 and 1980, as opposed to 14.7 percent for the hospital industry as a whole. (See Chart I.)

Public hospitals have managed their resources more efficiently. A recent study by Alan Sager indicates that public hospitals have experienced the largest decrease in length of stay, and the only increase in occupancy rate, among all classes of payors in the nation's 52 largest cities. Moreover, public hospitals have decreased the total number of beds between 1970 and 1980—by over 22 percent—in those cities.

Public hospitals are important providers of primary and ambulatory care to poor persons who often have little or no access to private physicians. Just 23 of NAPH member hospitals had 5,254,839 outpatient visits and 2,150,855 emergency room visits in 1980 alone. The total represents nearly 3 percent of all the OPD visits to all 5,830 community hospitals surveyed by the American Hospital Association—for these 23 hospitals alone!

There is a growing body of data which indicates poor patients are sicker, often have multiple diagnoses, and require more expensive care. In addition, such patients also require a range of other unique nonmedical services, such as translators, nutrition educators, social workers and specially-trained discharge planners, which adds to the cost of their care.

HOSPITAL INFLATION: PUBLIC HOSPITAL COSTS INCREASED SIGNIFICANTLY SLOWER THAN INDUSTRY DURING 1976-1980



SOURCE:
AHA DATA
AND NATIONAL
ASSOCIATION
OF PUBLIC
HOSPITALS
SURVEY [illegible]

Public hospitals often provide special public health and other unique services to their entire community, not just the poor. These services are often too costly or too "Unreimbursable" for most private hospitals to maintain. They include burn units—trauma centers—emergency alcoholism, drug abuse, and child abuse centers—neonatal intensive care—poison control units—to name just a few.

Yet many of these special, community-wide services are also in jeopardy, due to substantial budget reductions in categorical health programs as well. From childhood immunization to alcoholism treatment to venereal disease control, actual dollar reductions and block grants have severely hampered the continued ability to perform many of these services.

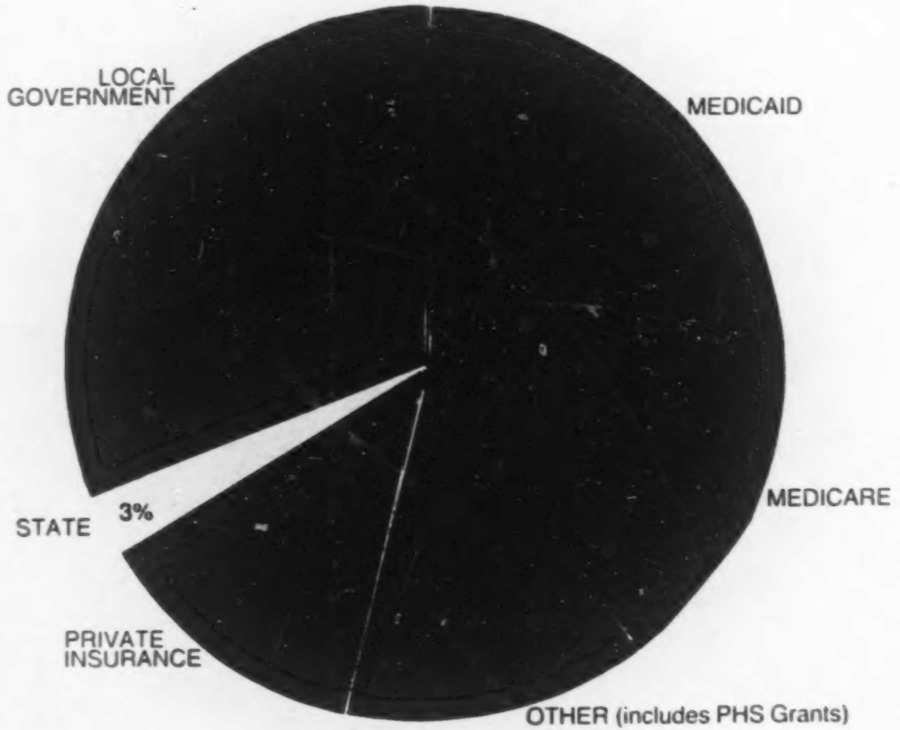
Despite the persistent Washington, D.C. myth that cities and countries are not paying their way, a substantial portion of the public hospital budget comes from State and local tax revenues. New NAPH data shows 34 percent of our members' budgets come from State and local appropriations, as opposed to 22 percent from Medicaid and 16 percent from Medicare. Of $2.07 billion in total revenues received by just 23 public hospitals in 1980, $709 million were from State and local non-Medicaid appropriations. (See Chart II.)

Public hospitals and other high-volume providers of care to the poor have far fewer private patients than most community hospitals. New NAPH data shows an average of just 12 percent private paying patients for urban public hospitals across the country. Unlike private hospitals, public hospitals have nowhere to shift costs when governmental funding is cut.

Urban public hospitals remain the backbone of our medical education system, yet that role too may be threatened by reduced governmental support. New NAPH data shows that just 24 of our member hospitals trained nearly 6,000 of our nation's interns and residents last year. This represents over 10 percent of all the interns and residents trained in America, for these 24 hospitals alone.

An appendix describing in greater detail the patient population served by public hospitals, the services they provide, their sources of payment, and some of the special needs of their patient population is attached to this testimony.

SOURCE OF REVENUES: NAPH MEMBER HOSPITALS, 1981



SOURCE: National Association of Public Hospitals Survey

THE ADMINISTRATION'S PROSPECTIVE PAYMENTS PROPOSAL: PUBLIC HOSPITAL CONCERNS

At the outset, let me state that NAPH joins with the American Hospital Association and others in fully supporting the current trend toward a comprehensive, equitable prospective payment system for hospitals and away from the confusing assortment of cost and charge-based payment mechanisms which have characterized our reimbursement system to date. We are concerned, however, that there have developed over the past year a great many "prospective payment" proposals for reform at the Federal and State level. We believe the various elements of these proposals need to be carefully evaluated before a new system is legislated, along with the as-yet-unknown impact on our nation's hospital system of the many recent changes in Medicare and Medicaid reimbursement laws and policies.

We are particularly concerned about the impact on the possible future implementation of any new prospective payment system of the Administration's apparent lack of regard for this Committee's concern about the needs of hospitals serving the poor. We believe the new Medicare reimbursement limits under TEFRA will substantially penalize public hospitals for prior efficiencies—while taking no account of the additional resources required by our patients. We are understandably concerned and dismayed that the Administration has refused thus far to acknowledge despite a clear Congressional mandate that public hospitals should receive an adjustment to the TEFRA limits to recognize the uniqueness of our public mission and the patient population we serve. NAPH is now engaged in an extensive debate with HCFA over their failure to provide such an adjustment—a debate we may need to ask Congress to resolve through a clarification of your clear recognition of the important role played by our "safety net" institutions.

In the balance of my testimony, I would like to turn briefly to the specifics of the Administration's current DRG-based proposal. We will undoubtedly have additional comments when draft legislation has actually been prepared and made available. However, we would like to make several general observations about what we believe are some of the proposal's current deficiencies from the point of view of public hospitals.

1. The proposal applies only to medicare inpatient services

While we recognize the current political impracticality of any prospective payment proposal which would apply to all payors, we question the wisdom of Congress adopting a new system at this time which does not. Nor can there be genuine reform, in our opinion, unless the services and resource needs on the outpatient side are also taken into account.

2. The proposal makes no provision for hospitals serving significant numbers of low income patients

Cost shifting is a very real phenomenon today, and under our current reimbursement system, a necessary one—particularly as long as all payors continue to receive one form or another of taxpayor subsidy. As pressure increases among payors to end or reduce cost shifting, however, the patients whose costs must be shifted will become increasingly isolated. When no organized insurer admits to any responsibility for serving the uninsured poor, those patients will increasingly be dumped on our nation's public hospital system—at least up to the limits of local taxpayers' willingness to support that tremendous burden. After those limits are reached, they will simply be dumped period. While the common wisdom is that Medicare should assume no responsibility whatsoever for non-Medicare patients, we believe that wisdom must be challenged when it comes to our "safety net" providers. In those institutions, at least, services provided to uninsured patients must be factored into any major prospective payment reform.

3. NAPH has serious concerns about the DRG system upon which the administration's proposal is based

Our significant concerns about the DRG system include the following:

DRGs appear to be inadequate to take into account the tremendous variation in resources which can be required by patients with the same principal diagnosis. Dr. Susan Horn, of the Johns Hopkins University, has pointed to one DRG, for example, in which the charges varied within a single hospital from $400 to $59,000. We believe that low income patients are far more likely to require additional resources than middle class patients with the same diagnosis.

DRGs are also inadequate to take into account the greater resource needs of low income patients who are more likely to have several different diagnoses. Public hospital septicemia patients, for example, are 2½ times more likely to have tuberculosis than those in private hospitals. Moreover, many of the disease categories more prevalant among public hospital patients—mental illness, trauma, infection, diabetes—are those in which patients are more likely to require a wider range of resources.

DRGs discriminate against patients whose needs can be served without surgery despite the fact that such patients in public hospitals may have equal or greater resource requirements. Public hospitals perform far fewer elective surgeries than their private counterparts, for example, and our patients are far more likely to be admitted through the emergency room.

By expressing the goal of narrowly defining the number of "outlier" cases for which reimbursement will be available outside the system, the proposal will substantially discriminate against public and teaching hospitals. Recent studies have shown that 3.5 to 7.1 percent of all public hospital discharges are "outliers", with longer than average length of stay, as compared with 1.7 to 3.9 percent in non-public hospitals. We have also analyzed HCFA's own data regarding "outliers", and have discovered a substantially greater proportion in urban hospitals than in all hospitals. We have reviewed information from HCFA's Health Standards Quality Bureau, based on 90 percent of 1980 Medicare discharges (not just a 20 percent sample). For the top 27 Medicare DRGs, which accounted for about 30 percent of total Medicare discharges, 1.79 percent of the discharges overall were outliers by the Health Standard Quality Bureau's definition. However, in 9 major urban areas—Los Angeles, Washington, D.C., Baltimore, Chicago, Boston, Detroit, New York City, Cleveland, and Philadelphia—3.09 percent of the total cases were outliers. We will provide a more detailed analysis of this data and its implications for the record.

Unless appropriate safeguards are built in to a DRG-based system, there will be tremendous pressure on private hospitals to transfer their sicker, more complicated cases within a particular DRG to the hospitals who cannot refuse them.

Even if such DRG-induced dumping does not occur, there will be no incentive whatsoever in such a system to care for healthier patients in less costly outpatient settings. Indeed, healthier patients within particular DRGs will become prizes to be wooed and won by hospitals with the luxury to compete for them. Thus, with a single stroke, this so-called "reform" will end any prospect of substantial future savings from current positive trends away from unnecessary hospitalization.

In addition, many patients themselves will get "sicker" under a DRG system—at least on paper. "DRG creep" and other exotic phenomena will become the order of the day, as hospitals seek to maximize reimbursement-by-diagnosis under the new system. Anecdotally, at least, this phenomenon appears already to be occurring in New Jersey—along with other less pleasant stories about hospitals discharging patients before they are well, in order to be able to admit them again under a different diagnosis. If these stories prove to be fact, the system will have created some perverse incentives indeed.

Finally, DRGs also fail to take into account the teaching and educational costs which are incurred by primary teaching hospitals. While the Administration proposal expresses the goal of "passing through" certain teaching costs, the adequacy of that pass through will have to be carefully examined.

In short, the prospective payment plan based on DRGs fails in many respects to take into account the uniqueness of the nation's urban public hospitals. Furthermore, it hardly seems reasonable to jump into a radical new financing scheme if we expect it to generate further savings, when we are all still evaluating the impact of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which is expected to reduce Medicare reimbursement by $12.5 billion over the next three years.

I must point out that unlike private hospitals, public hospitals are not rewarded for increased consumption. They operate on a predetermined budget, much like a health maintenance organization. Unlike an HMO, however, public hospitals cannot open and close our enrollment period as economics dictate. Their doors are always open or will be until local elected officials decide to get out of this business.

While the DRG formula poses a specific problem for public hospitals, it is not as disturbing and as frustrating as the overall tendency among governmental decision-makers toward false economies and contradictory policies in the area of health care. On the one hand, Administration after Administration in Washington preaches the need to rein in health care costs, a goal which public hospitals whole-heartedly endorse. On the other hand, the Administration and Congress persist in chipping away at the community health centers, family planning, prenatal care, nutrition, and other preventive programs, which in many instances are far more cost-effective than hospitalization programs. Instead of supporting preventive care and early intervention, the government continues to promote crisis care, which is the most costly, both in human and financial terms. The government is zeroing in on the providers of medical care, while all but encouraging growth in the legitimate demand for health care. Cost reduction and crisis care are simply incompatible concepts in our health care system.

In summary, while we will have additional comments once we have had a chance to read and consider the Administration's draft bill, and also support many of the concerns raised by AHA, AAMC, and others, we believe there are three major issues of paramount importance to public hospitals for the Committee to consider:

(1) The Committee should strengthen the statutory requirement you adopted last summer that an adjustment be provided to the Medicare TEFRA limits to address the special needs of hospitals serving substantially disproportionate numbers of the poor. As the Senate Finance Committee report made clear last summer, this adjustment should be retroactive to the beginning of the current fiscal year.

(2) Build into any new set of prospective rates you may adopt an allowance for charity care and bad debt, at least for our nation's "safety net" institutions, to recognize the importance to our entire health system of their role as the hospitals of last resort for the poor. There is ample precedent for Medicare recognition of at least some factor for bad debt, in waivers granted to prospective payment systems in New York, Massachusetts, Maryland and New Jersey.

(3) Finally, we strongly urge the Committee to adopt a more liberal policy that the Administration is proposing to pay hospitals the actual cost of serving "outlier" patients, at least in those hospitals (and those parts of the country) where the incidence of such patients is likely to be higher than the national average.

HEALTH CARE FOR THE UNEMPLOYED

In closing, I would like to depart for a moment from the expressed purpose of this hearing to ask the Committee to focus attention on a current problem of equal or greater importance to the nation's health care "safety net" than piecemeal "reforms". I am referring to the tremendously increased demand for public hospital services as a result of the current economic recession.

It is being graphically demonstrated in the current economic crisis that people without adequate health insurance coverage postpone needed health care until they are too sick to refuse it. Then—when they are more expensive to treat—they become bad debt or charity care patients in private or public hospitals. In private hospitals, unless a patient can become Medicaid eligible, the costs of their care are shifted largely to insured patients. In public hospitals, the shift is to local taxpayers, whose systems are supported through severely regressive property and sales taxes. One way or another, the public is footing the bill—but for patients whose problems may be more costly and serious than when they should have sought care.

With a rate of unemployment at depression levels in many parts of the country, Congress should clearly move to try to fill at least some of the health care needs of unemployed workers who have lost their insurance coverage. This is a problem which has been a subject of attention for Congressional policymakers in the past. But earlier pressure for passage of legislation was alleviated by a combination of factors, including the fact that workers in some industries (such as the auto industry) were able to negotiate contracts including extended health coverage during periods of unemployment.

Many unemployed workers today enjoy no such protection, however. For a variety of reasons, unemployed workers are unlikely to become eligible for Medicaid in many states. Thus, the burden of providing health care for such individuals and their families will inevitably fall on the cities and counties, and their public health and hospital systems.

For this reason, we propose that Congress adopt at least a limited, targeted assistance program for the coming fiscal year which would provide additional support to state and local governments, or coalitions of private and public providers, to help contend with this problem.

We have not drafted a specific legislative amendment to accomplish this goal. Rather we would be happy to work with the members of this Committee to carefully develop a responsible, limited bill for consideration as part of health or jobs legislation.

Whatever the specific provisions or safeguards of such a bill, we believe it is an essential and humane countercyclical measure to maintain the stability of our health care system at a time of economic crisis, and care for some of the individual Americans who (through no fault of their own) have fallen victim to that crisis. If a relatively tight cap is placed on total funds available for such an effort, it would cost just a small percentage of the amount President Reagan's third year tax cut will throw away later this year.

I appreciate the opportunity to testify today, and I would be happy to respond to any questions you may have.

Chairman JACOBS. Ms. Klafter.

STATEMENT OF FRANCES KLAFTER, CHAIRPERSON, NATIONAL HEALTH TASK FORCE, GRAY PANTHERS

Ms. KLAFTER. Thank you very much for the opportunity of appearing today.

I have an accompanying statement. My statement is very brief. I just want to point out that it seems most appropriate for me to be the last witness at this hearing since I am speaking on behalf of the beneficiaries of the medicare program, with the plea that whatever system of payment is adopted, have built in quality controls. Our feeling is definitely that the proposal does not have adequate built in quality controls, that it does not protect medicare beneficiaries from discrimination. We do not want to be reduced to second class patients in hospitals.

It would appear that any prospective payment system adopted cannot adequately protect the beneficiaries if it does not cover all payers. But particularly we urge this committee to proceed with caution, as it so far has given every indication of doing, and not hasten to adopt a payment system that might lead us from one bad system to another.

Certainly we are putting great hopes in this committee that has given such attention to protecting the medicare program from benefit cuts in the past and we hope that that care and caution will continue in the future.

Thank you.

[The prepared statement follows:]

STATEMENT OF FRANCES KLAFTER, CHAIRPERSON, NATIONAL HEALTH TASK FORCE, GRAY PANTHERS

Thank you for the opportunity to participate in this hearing.

I am Frances Klafter, speaking for the Gray Panthers. I work as a volunteer, helping to organize a nationwide grassroots health advocacy network. I have been a Medicare beneficiary for about nine years.

The Gray Panthers congratulate this Subcommittee and its parent Committee, first, for having played a leading role in the Congressional mandate for a prospective reimbursement system for hospital services to Medicare beneficiaries, and second, for moving with caution to assure that the payment system adopted is an effective one. We hope that this care and caution will continue, and that the Subcommittee will not be pressured into approving changes in the payment system too hastily. There is certainly nothing to be gained by going from one payment system that is not working to another.

The so-called "health care system" has been careening out of control for some time, with parts of it falling off, clinic by clinic and hospital by hospital, as spiraling costs render them no longer "cost effective," but not necessarily no longer needed. The people in need of health care are the victims. The beneficiaries of open-ended government programs that have invited health care providers to help themselves are the victims. We do not want a payment that is adopted now to victimize the beneficiaries further.

The staff of the Health Care Financing Administration has obviously put a great deal of time, effort and thought into the reimbursement proposal they have presented. The concerns that I express here about this proposal are certainly not original—they have been expressed many times over in hearings and briefings about the proposal, not only by advocates for the elderly but by others seeking to assure quality of care for patients in the nation's hospitals.

We question whether the patients whom changes in the reimbursement system should be designed to serve—the nation's elderly parents, grandparents, aunts and uncles lying ill in hospitals—will be assured quality health care under the proposed plan. We question further its effectiveness in containing hospital costs in its present form.

As to quality of care, when questions have been raised with representatives of the Department of Health and Human Services about the danger of too early release of patients, they have pointed out that fear of malpractice suits would be a great deterrent to this. We do not consider this an adequate safeguard. Furthermore, our fears of inadequate quality control are intensified by the fact that at the very time that a system is being proposed that would give hospitals an economic incentive to provide a minimum of patient care, the Department has also issued proposed revisions of regulations for conditions of participation of hospitals in the Medicare and Medicaid programs. These proposed revisions, we believe, would threaten the health and safety of patients in the nation's hospitals. We insist that enforcement of strong regulations to insure quality of patient care should not be axed in the name of cost containment.

A further concern, which has to do with both quality of care and the effectiveness of the proposed system in containing costs, is the fact that, as presented, it would cover Medicare only.

We do not want Medicare beneficiaries to become second-class patients. We have long been trying to help protect Medicaid patients from the kind of humilation, rejection and limitation on access to quality care being second-class patients entails. We do not now want Medicare patients to suffer that fate.

We also join in questioning the danger of cost-shifting to other payors in a reimbursement system that would regulate hospital charges for Medicare beneficiaries only.

It seems clear that a hospital reimbursement system that will avoid discrimination against one group of patients and will be truly effective in controlling charges, must include all payors—Medicare, Medicaid and private insurers. We realize that there are problems involved in implementing such a system, but those problems have apparently been surmounted in those states where prospective reimbursement systems have been the most effective. We also note that Congressman Ron Wyden's Medicare Reform Payment Bill, H.R. 1227, recognizes the necessity of including all payors in an effective system of hospital prospective reimbursement.

The Gray Panthers have long been critics of our increasingly chaotic fee-for-service nonsystem of health care, which has now reached the point of making routine health services luxuries for much of the population. We hope that the proposals being discussed here today will help to temporarily prop up the Medicare program, so that beneficiaries can continue to receive at least its limited benefits, until the happy time comes when the nation will turn its attention to debating what kind of health care system we should have.

We support the concept of a National Health Service, as described in Congressman Ronald V. Dellums Health Service Bill, introduced in the last several Congresses, but not yet introduced in the Ninety-eighth. Others favor a system of national health insurance. We look forward to the day when these will be the issues we are discussing before you. In the meantime, we look to you to protect the still quite inadequate benefits available under the Medicare program.

Chairman Jacobs. Thank you, Ms. Klafter.

Mr. Duncan.

Mr. Duncan. Thank you, Mr. Chairman.

I want to thank both of you for your excellent statements.

Mr. Gage, the hospitals you represent, are they mainly urban hospitals?

Mr. Gage. They are a combination of urban and I would call urbanized, suburban area hospitals. There are intercity hospitals and there are hospitals like Nassau County which is in a heavy urbanized area, but outside of central New York City.

Mr. Duncan. Any in rural areas?

Mr. Gage. We have a couple of members particularly from our earlier days when we needed the money who are in rural areas.

Basically it is urban and suburban hospitals. That does extend to areas like Fresno, Lexington. They are not a member, but we have been in close touch with several of the hospitals in smaller cities.

When we compiled out of the BLS data a list of the 30 cities with the highest unemployed in the country, we noticed a number of those are among our smaller cities.

Mr. DUNCAN. Thank you very much.

Thank you, Mr. Chairman.

Chairman JACOBS. Ms. Klafter, have you an opinion concerning the so called voucher proposal?

Let me divide that into two parts.

I am talking about voucher proposal generally and the specific one that was enacted last Congress for the HMO's.

Ms. KLAFTER. What they call the HMO voucher proposal?

Chairman JACOBS. Yes.

Ms. KLAFTER. First, I would like to talk about vouchers in general because we certainly have opposed the idea of vouchers. If you want to pay people for using less health care, I guess there are a lot of ways to do it and that might be one.

We don't think that the main aim and goal of this country should be to persuade people to use less health care. We think it should be to have better health care and certainly to use health care wisely and to have preventive health care.

We don't see that the voucher system would solve any of those problems. It would deprive the people, particularly the poorest people who need it most, of health care because they might unfortunately be very happy to sell their chance to buy an insurance policy for much needed ready cash. Then what are you going to do when they get ill?

Chairman JACOBS. You mean a birth right for a mess of potage?

Ms. KLAFTER. On the HMO voucher, we have supported the concept of HMO's and many of our members are in HMO's. We would certainly hate to see the voucher system sort of slip into the back door by way of the HMO's.

We are getting lots of complaints from our members about some of the HMO's that are hastily forming, being sort of health care mills. We are concerned and are watching that. We don't want the HMOs to be subverted by having to be a back door entrance to the voucher system.

Chairman JACOBS. Thank you.

Mr. Gage, you said that national health insurance is no longer a necessity.

Mr. GAGE. No, sir. I said it is no longer being debated.

Chairman JACOBS. Do you think it is a necessity?

Mr. GAGE. I think definitely some form of health insurance that fills in some of the significant gaps in our system.

Chairman JACOBS. I take it you feel public hospitals made it not quite so necessary?

Mr. GAGE. We have used substantial local resources. We did a survey. A lot of people in Washington think cities and counties pay their way in health care systems, but 35 percent of our budget is paid for by cities and counties.

That goes for uninsured people including people who might spend their voucher money on other things. So we believe that if we didn't exist, there would be a much more substantial need and you would find a lot more support among hospitals and the AMA and others for some form of national health plan.

Mr. DUNCAN. You indicate that your hospitals take everyone regardless of whether they can pay or not?

Mr. GAGE. That is correct.

Mr. DUNCAN. If they are doing that, why would you need national health insurance?

Mr. GAGE. Because all of the sources of payment for these hospitals are being reduced. As one of my members said, if you are losing money on one patient, it is hard to make it up in volume. We have administered these hospitals through block grants, alcohol grants, health care, medicaid, and State and local contribution.

There is not a city council or county board that will substantially increase taxes in the next term. There is not a prospect for increase in any of the other payment programs to pay for public hospitals. There are very few private patients in most of our hospitals.

While we strongly support cost shifting, we don't really get to take much advantage of it because cost shifting and public payer programs right now are the whole ball game as far as national health insurance goes.

Mr. DUNCAN. Do you think the cities and counties are so hard hearted if people actually need medical care they wouldn't provide it? Is that what you are saying?

Mr. GAGE. I think it is a combination perhaps of hard hearted and in some parts of the country where cities and counties may well have a substantial tax base that is untapped. If you look at political reality of getting elected to a city council or county board of supervisors today, the trend is definitely in the opposite direction.

The Proposition 13's, Proposition 2's. Few of them are willing or able to commit political suicide.

Yes, I think in some parts of the country there will probably have to be an increased commitment at that level.

Mr. DUNCAN. Do you know any communities that actually turn people away from hospitals that need help? You indicate that you are an exception?

Mr. GAGE. I know of situations in almost all communities where people are turned away from even the public hospitals for one reason or another. Often public hospitals operate at 107-percent occupancy and cannot accept patients.

Hospitals often discharge a patient early because they have a more critically ill patient.

Mr. DUNCAN. If there is a bed and they need it, they are accepted?

Mr. GAGE. If there is a bed even in those parts of the country which have pretty strict rules about in-county versus out-of-county indigents, you will find in the larger cities they will not turn people away.

Mr. DUNCAN. Thank you.

Thank you, Mr. Chairman.

Chairman JACOBS. That is good testimony. Thank you very much. This concludes the hearing.

[Whereupon, at 1:10 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Alabama Hospital Association,
Montgomery, Ala., March 2, 1983.

Hon. Andrew Jacobs, Jr.,
Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives, Washington, D.C.

Dear Mr. Jacobs: On behalf of the Alabama Hospital Association (AlaHA) and its 145 member institutions, as well as its over 550 personal members, I would respectfully request this letter be made a part of the hearing record of February 14 and 15, 1983, regarding the Medicare Prospective Payment System. AlaHA greatly appreciates the opportunity to share with you and the Subcommittee our views and comments.

AlaHA is committed to a goal of access to quality health services for all people so as to avoid a two-tiered level of care. AlaHA is greatly concerned about the escalating costs of health care in our state and nation. We have expressed our belief that the antiquated cost-based, retrospective payment system under Medicare has contributed to cost escalation. Overhauling this system of retrospective reimbursement so as to provide a framework for control of this escalation is another goal of Alabama hospitals. At the same time, we must insure that in any hospital payment methodology, rational and realistic funding for hospital services is provided for. These three related goals are the cornerstone for our comments on developing prospective payment concepts.

GENERAL COMMENTS

The Alabama Hospital Association is supportive of a prospective payment system for Medicare. We are convinced that this is the only viable option to the current cost based system. If a prospective payment system is carefully designed to shift current misplaced incentives for providers, while providing rational and realistic funding for hospital services, the problems of escalating costs and cost shifting can be brought under control. Such a system can inevitably benefit the Medicare beneficiary and private paying patient in addition to producing significant long range program savings for the government.

SPECIFIC COMMENTS

While there are numerous approaches as to what a prospective payment system should include, AlaHA will limit its specific comments to principles set forth in the Department of Health and Human Services plan submitted to Congress in December, 1982. Our comments so outlined may be of greater assistance in your deliberations.

HHS is to be commended for its work on this proposal. AlaHA believes that this plan is an excellent starting point for Congressional consideration. (A listing of the HHS plan principles with our suggestions follow:)

Treatment of freestanding/specialty hospitals

The HHS proposal addresses this issue, and is a principle supported by AlaHA.

Coverage of services based in general hospitals

The HHS proposal limits prospective payment coverage to inpatient acute care. This is a principle supported by AlaHA.

Cost reports and audits

The HHS proposal inadequately addresses the cost reporting and audit burden currently existing under the retrospective system. One of the goals of the HHS proposal is a reduction in the administrative burden of the Medicare program. Hospitals should be able to share in the benefits of such reductions, so that our administrative costs can be lowered.

Effective date

The HHS proposal calls for hospitals to come onto the system with fiscal years beginning on or after October 1, 1983. The AlaHA supports this effective date and the rolling on of hospitals fiscal years.

Expiration date

The HHS proposal does not call for an expiration date to its proposed program. AlaHA feels that an expiration date should be included, so that an opportunity for Congressional evaluation and reauthorization of the proposal could be facilitated. AlaHA would, therefore, suggest an expiration date of October 1, 1987.

Beneficiary liability

(A) Copayments and Deductibles.—HHS has proposed a continuance of currently required copayments and deductibles. This is strongly supported by AlaHA. Additionally, AlaHA supports restructuring of the copayments and deductibles so as to account for when elderly patients actually require treatment and when the intensity of service occurs. Our Association feels that copayments and deductibles can be structured in such a fashion as to reduce the financial burden that is placed on the elderly and equitably recognize hospitals financial requirements. Constructing a Medicare days savings plan, which would permit the elderly to accumulate over a period of years sufficient days to meet catastrophic illness needs, has great merit.

(B) Assignment/non-assignment option.—The HHS proposal makes no provision for hospitals to elect to accept Medicare assignment. AlaHA strongly opposes this restriction. Hospitals, to prevent cost shifting, must be able to bill at least a portion of the difference between government payment and service costs. If access to quality care is to be provided, and the development of a two-tiered system of care avoided, hospitals' ability to elect assignment or non-assignment must be provided for.

Unit of price

The HHS proposal calls for a national unit of price utilizing diagnostic related groupings (DRGs) adjusted regionally for wages. Without a doubt, no other issue of the HHS proposal so sharply divides the hospital industry as does the issue of DRGs. The AlaHA is opposed to the use of DRGs as the unit of price for a prospective payment system. We do endorse the use of a national average cost-per-case unit of price that would be adjusted regionally for wage differences as well as adjusted for unusual lengths of stay on a per-case-basis. The validity of DRGs as a payment mechanism is highly questionable. Furthermore, the DRG experience in the only operational system that exists, has demonstrated its inability to realistically accommodate secondary diagnoses which result in prolonged length of stays. Strangely enough, the high cost institutions, we believe, will be protected under a national DRG approach, to the detriment of the more efficient institutions. A national average per case can be easily implemented and would protect the historically efficient institutions. High cost facilities would automatically be given an incentive to reduce costs.

Initial year's base

The HHS proposal calls for a national average cost with an area wage adjustment to be used for determining the initial year's inpatient acute prices. AlaHA opposes this approach and recommends instead the use of individual hospital's costs. The AlaHA believes that determinations made from the base year will be crucial to the long range viability of hospitals under the system. This initial base year should come from the most recently filed Medicare cost report that has been updated through the end of the preceding fiscal year. A final base year should be determined by submission of a special Medicare cost report showing each hospital's actual cost performance, to reflect measurement of hospital input prices. The fixed price would then be adjusted to reflect the final base.

(A) Disallowed costs.—In calculating the initial and final base year, the question of disallowed costs must be addressed. AlaHA, at a minimum, supports inclusion of: Hill-Burton uncompensated services treatment as bad debt; unusual malpractice costs; and unusual labor cost settlements.

Base adjustors

The HHS proposal leaves future inflation and technology adjustments to the base year, to Secretarial discretion. AlaHA opposes this approach.

(A) Inflation.—AlaHA would support instead the use of a panel of economists, independent of government and hospitals to annually set an annual measurement of hospitals' input prices, i.e., an inflation factor. This market basket method should be legislated into a prospective payment system. This inflation factor should take into account at a minimum increases in depreciation, interest, and related financial costs.

(B) Technology.—In addition to an inflation factor, the base adjustor must include a factor that recognizes hospitals' cost increases due to advances in technology. This portion of the adjustment index must be at least the average technological cost increase for previous fiscal years or hospitals must be permitted to use purchase level depreciation for new technologically related equipment.

Capital costs.

The HHS proposal provides a pass through for capital costs. This is support by AlaHA.

Medical education costs

The HHS proposal provides a pass through for medical education costs. Likewise, this is a provision supported by AlaHA.

Treatment of small rural hospitals

The HHS proposal provides for exceptions to their prospective system for sole community providers. AlaHA supports this provision but would refine it to also include an exception for small rural hospitals.

Treatment of newly constructed hospitals and change in ownership

The HHS proposal does not address how it will treat newly constructed facilities as well as what will happen when the ownership of a facility changes. AlaHA supports the inclusion of a provision making an allowance for those hospital base years.

Capital maintenance/return on equity factor for hospitals electing assignment

The HHS proposal does not reveal how capital maintenance will be addressed and the continuation of return on equity is unclear. AlaHA feels that both factors must be addressed for hospitals accepting assignment.

High medicare volume hospitals

The HHS proposal does not include any special treatment for high Medicare volume hospitals with low income patients. For the protection of these facilities under the system, AlaHA supports a special price adjustment factor for these facilities, especially those with sole community provider status.

Exceptions and appeals

Besides an exception for sole community providers and the elimination of hospitals' access to judicial review, the HHS proposal makes no provisions for exceptions and appeals.

(A) Exceptions.—AlaHA would support the delineation as to the grounds whereby exceptions can be obtained and the criteria to be used by the Secretary in making those determinations.

(B) Appeals.—AlaHA would support the creation of an independent panel representing government, labor, business, and hospitals to act as an appeal review board, whose decisions could only be overturned by the federal courts.

Utilization control

The HHS proposal does not address how hospitals with deemed status will be treated. AlaHA supports the inclusion of the concept of deemed status for those hospitals that have demonstrated effective utilization control programs.

Waivers and demonstration projects

The HHS proposal makes no provision for the granting of waivers and demonstration projects. To insure that the prospective payment system is subject to review and improvement, AlaHA would support the inclusion of a provision allowing the independent review board mentioned earlier powers to grant waivers for demonstration projects. These projects reasonably would not cost the established system more and could prove beneficial to the future workability of prospective payment.

CONCLUSION

Prospective payment for hospitals is greatly needed to replace the current cost-based retrospective system. The hospitals of Alabama share your concern for the interent problems of the present system resulting in increasingly higher medical costs, a depletion of the Hospital Insurance Trust Fund, and added strains on the federal deficit. AlaHA realizes that a move to prospective payment will not be the cure all for this country's health care problems, but it will at least provide the catalyst for much needed change. The purpose of our comments are strictly to offer our advice as to how we believe the goals of Congress on this matter, and those of hospitals in Alabama, may best be served.

Please contact me if I can provide you with further information or details on the statement.

Sincerely,

W. H. (Hoke) Kerns,
President.

STATEMENT OF ARTHUR BERNSTEIN, M.D., PRESIDENT, AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE

The American Association of Foundations for Medical Care (AAFMC) is the only national association which represents Individual Practice Associations (IPAs), IPA-type Health Maintenance Organization (HMOs) and Foundations for Medical Care (FMCs).

Since its founding in 1971, AAFMC has been in the forefront of the fast growing HMO community promoting the development of IPA-type HMOs and programs aimed at assessing the quality and appropriateness of health care services.

The history of AAFMC is highlighted by the pioneering work done by the early FMCs. Begun in 1953, these forerunners of today's IPAs are successful and growing.

AAFMC member plans offer programs of comprehensive benefits that stress quality of care. AAFMC and its members work with industry, labor and insurance companies in developing and offering comprehensive health programs that emphasize quality assurance and cost effectiveness through sophisticated utilization review programs. They represent health programs that are cost effective by building around existing facilities and services.

AAFMC's 1981 membership included 109 plans representing 31,010 participating physicians and a combined enrollment of approximately 2,243,000.

Association membership continues a steady growth as the popularity of Individual Practive Associations and Foundations for Medical Care increases.

Members of AAFMC participate in a wide range of activities and educational programs.

AAFMC policy is established by a House of Delegates and a Board of Directors elected by the House of Delegates.

AAFMC maintains the International Institute for Health Care Alternatives, a non-profit organization established to provide consultative services and technical assistance to organizations and governments within the United States and in other parts of the world.

We appreciate this opportunity to comment on the DRG-based hospital reimbursement system which the Department of Health and Human services has proposed to the Congress.

HMOs are vitally interested in this proposal since its inappropriate application to HMOs could deprive our members of their competitive advantage in the marketplace, particularly under the revised system of Medicare reimbursement for HMOs in risk contracts which this Committee approved as part of the Tax Equity and Fiscal Resonsibility Act last year. These changed provisions have much encouraged our members to bring the advantages of their operation to Medicare patients. The major theory under these changes is that HMOs can save money for the government and still provide additional services to Medicare beneficiaries through their unique efficiencies in providing health care.

One of the principal ways in which our members perform more efficiently than the health system outside HMOs is our ability to make special arrangements with hospitals on the rates to be paid but, more importantly, to restrain unneeded hospital admissions, lengths of stay and in-hospital services.

HMOs would lose these advantages if they were required to pay hospitals on a DRG basis. If an HMO paid a hospital on a DRG basis where the lengths of stay are, in effect, averaged, it would be paying the hospital more than its fair share if HMO admissions were, on average, less costly within each DRG than the general health delivery system in an area. For example, if an HMO were able to get their surgical patients out of the hospital a day earlier than for similar patients outside HMOs, it would be the hospital, not the HMO, which would gain.

It is for this reason that we were pleased to see recognition of this problem in the Department's report to Congress on DRG. On page 57 of the report is the following statement:

Health maintenance organizations provide hospital and other services to approximately 10 percent of the population including nearly 3 percent of the Medicare population on a pre-paid capitated basis. Therefore, HMOs have a strong interest in keeping people well and out of the hospital.

Section 114 of TEFRA allows payment to be made on behalf of Medicare beneficiaries on a per capita basis for those HMOs under a risk sharing contract. The statute requires the per capita rate to be 95 percent of the expected cost in the current fee for services system, and many believe that the majority of HMOs will enter such agreements. PPS will not change this arrangement for HMOs which choose risk sharing contracts. However, the statute also allows HMOs to be paid on a reasonable cost basis. In PPS, the Department believes that these HMOs should be paid the same prospective rate as would be paid to other hospitals. Thus, the non-risk sharing HMO would be paid what otherwise would have been paid to any hosptial.

We urge the Committee to give risk-taking HMOs complete freedom to make their own reimbursement arrangements with hospitals or to use the Medicare system, as recommended by HHS. While cost-reimbursed HMOs should generally follow the usual Medicare policies for paying hospitals, as also recommended by the Department, we see no reason to prohibit a cost-reimbursed HMO from using another method if costs to Medicare would be lower.

We appreciate this opportunity to make our views known to the Committee by inclusion of our statement in the record of hearings.

AMERICAN COLLEGE OF GASTROENTEROLOGY,
Manchester, Mass., February 25, 1983.

HARLEY M. DIRKS,
Health and Medicine Council of Washington, Inc., Stanton Square, 420-C Street, NE, Washington, D.C.

DEAR HARLEY: I am writing this letter to you to express the concern of the American College of Gastroenterology on the medicare hospital prospective payment system proposed by the Administration. Commonly, the prospective payment is referred to as the Diagnosis Related Groups (DRG).

The American College of Gastroenterology is concerned that it does not know the disease related groupings as pertaining to gastroenterology and is not aware whether the grouping allows for an unexpected occurrence occurring while in the hospital for another diagnosis grouping. For example, if a patient is admitted to a hospital for the treatment of an acute myocardial infarction and subsequently has massive gastrointestinal bleeding requiring endoscopy and perhaps either surgery or intensive medical therapy, whether the DRG system is flexible enough to recognize that a complication has occurred and will thereby modify its grouping allowing longer hospital stay.

In addition, the American College of Gastroenterology is concerned that the system only restricts medicare payments and could result in diminished quality care for patients being discharged from the hospital prior to the time that they are medically ready. In addition, the American College of Gastroenterology is concerned that the DRG system has not been adequately tested in field trials, and has not been proven to be cost effective nor more importantly, provide for quality care of medicare patients. Concern exists whether the DRG reimbursement system will result in further cost shifting to non-government payers.

Lastly, the American College of Gastroenterology suggests that prices for services be based upon an individual hospital's historical costs rather than basing DRG prices on national averages, with special allowances only for regional wage variations, medical education costs, and capital costs.

The American College of Gastroenterology would like these concerns to be respectively voiced to the Honorable Dan Rostenkowski, Chairman, Committee on Ways and Means for review during his current deliberations on this matter.

Respectfully,

JOHN P. PAPP, M.D., F.A.C.G.,
Chairman, National Affairs Committee,
American College of Gastroenterology.

STATEMENT OF THE AMERICAN FOUNDATION FOR THE BLIND PRESENTED BY GLENN M. PLUNKETT, SPECIALIST IN GOVERNMENTAL RELATIONS

Mr. Chairman and members of the subcommittee, I appreciate the opportunity to submit the following statement for the American Foundation for the Blind. The foundation is a nonprofit voluntary research and consultant organization in the field of services to blind persons of all ages.

In presenting our views on the prospective payment system, we express our concerns not only for those who are blind or visually impaired but for all medicare eligibles since the medicare program is the major health care program for the aged, blind and disabled who are eligible for social security benefits. Our concern is that whatever payment system or systems are installed, access to health care for the aged, disabled and blind not be curtailed.

We are cognizant of the rising costs of health care. Unfortunately all the other costs that the population at risk must bear continue to rise as well; leaving less and less to obtain health care at a time in life when the need is greatest. As you recognize, all efforts to date to restrain the cost of health care has been at the burden of those in need. For example, deductibles and copayments have increased and the part B premium has risen. Along with hospital and nursing home costs the medicare eligible must pay, physicians have increased charges and as a high percentage of physicians do not accept assignment, the users bear a greater and greater share of payment for medical services. All of those high cost services still do not include the out of hospital and out of nursing home prescription drugs which are not covered in any way by medicare. The cost of drugs will become a greater and greater cost burden for the aged, blind and disabled as they attempt to avoid the higher cost (to them) of hospitalization by self maintenance as long as possible. Naturally, such efforts may lead to higher cost hospital service at a later date when the individual's condition has deteriorated so that more intensive care, with costly technology, must be used to save him or her.

Actually, these are not problems which the aged, blind and disabled face alone; they are problems that we all face. We are caught up in a web of increasing needs, improved technologies, presumably an excess of medical doctors, an adequate number of hospital beds in most geographic areas, and increasing costs to the consumer as if the demand exceeded supply. However, the only proposed alternatives are those that attempt to restrain costs by reducing available services and by shifting more and more of the cost to the consumer in order to lessen demand.

A prospective payment system, especially one based upon diagnoses groupings would do nothing to alleviate the problem for the consumer of health services. It would not make more services available, it would not encourage alternative services and in all likelihood would make services for many types of illnesses, injuries, and diseases more difficult to come by on a timely basis. Regardless of case mix, rate setting, caps on expenditures by types of services or for certain cost centers, the net effect is on the individual in need of service. The service provider, whether the individual practitioner, hospital, or nursing facility is going to adjust its practices and services to maximize its returns to attain its actual or perceived economic goals.

Efforts to restrain rising costs through various methods are in effect in seventeen States; some of those have been in effect since 1969. The results of those efforts are mixed at the best and their effects on costs and health services are difficult to assess to any great degree of specificity. Some of the difficulties in assessing the results of cost containment are related to the geographic location of providers of services, size and type of population at risk, the relative mix of income groups, attitudes of users and perception of medical professionals who refer patients to providers as well as availability of professionals in the providers' facilities.

I respectfully refer you to the health care financing review of December 1982 (vol. 4, No. 2). That report includes research articles on such studies as "The Effects of Hospital Rate Setting Programs on Volumes of Hospital Services", "The Effects of Prospective Reimbursement Programs on Hospital Adoption and Service Sharing", "Hospital Payroll Costs Productivity, and Employment Under Prospective Reimbursement"; among others. The reports and conclusions from the studies leave the significant questions as to overall effects on costs, population at risk and providers of services unanswered, but a general conclusion can be drawn from the report that the cost containment factors as measured did not improve services or necessarily reduce program costs. For instance, the conclusion on hospital payroll costs, productivity, and employment under prospective reimbursement contains the following: "Results of tests on the payroll per day and FTE per day hypotheses support the argument that, under PR hospitals cut payroll costs and create productivity. However, price and skill-mix hypotheses, tested—show few statistically significant PR effects and great inconsistency in the size and direction (that is, positive versus negative) of these effects. Hospitals are subject to area wage movements, which are likely to be influences as much by labor supply force as by PR cost-cutting influences on hospital labor demand." The report further states that "We noted earlier the argument that apparent changes in "productivity" may be due to alterations in the amount and quality of services provided. Other preliminary NHRS findings suggest that hospitals may respond to PR by altering volume and service provision. According to Worthington (1980), Maryland and New York showed significant increases in occupancy rates and average inpatient length of stays that were associated with PR. Both findings are consistent with decreased total and payroll costs per day—one can argue that retarded service adoption is consistent with cost containment, and might be associated with FTE staff reductions". Quoting from the econometric results shown in the study "The Effects of Hospital Rate-Setting Programs on Volume Hospital Services: a Preliminary Analysis", a similar conclusion is drawn as that shown above, i.e. "Ratesetting programs are most likely to affect hospitalization in two ways: (1) By increasing the level of utilization, and (2) by influencing the annual rate of change in service use. Lighter budget constraints imposed by rate-setting programs that tie hospital revenue to units of service may give hospitals an incentive to increase the number of units provided. This may take the form of longer stays or the admission of more patients. As a result of these activities, the downward trends in hospital use described earlier may decelerate, if not reverse".

Our fears are that, regardless of the case mix, rate setting, caps on expenditures or whatever the combination of cost containment features that might be adopted, the aged, disabled and the blind will be adversely affected. We see the effects of cost containment proposals as reductions in access to health services by those most in need. We can see that providers will avail themselves of the most beneficial (to them) case mix by accepting higher paying diagnoses, by moving the lower payment diagnoses out quickly and maintaining a higher bed population of higher pay patients, i.e. heart attacks, cancer and other difficult cases needing more costly technology. Over the long run, especially in heavily populated urban areas, we may see hospitals devoted solely to treatment of higher reimbursement patients while those with lower reimbursement diagnoses are shifted to hospitals that would handle lower reimbursement level patients. Where such services are in plentiful supply and the medical care is as good as in the higher reimbursement hospital, such might not be a disservice. However, not all geographic areas would have sufficient facilities to accommodate a shift in bed populations and the lower level reimbursement patient may have to wait longer and longer for care. Again, the providers may well increase income by cutting out whole ranges of services and staffs to increase profit margins, yet reduce quality of care. As you recognize, individuals in rural areas and in smaller towns and communities seldom have a choice in hospital and nursing home services. Where such limited services exist, it will be difficult for the provider to obtain a case mix that will generate income relative to those in more urbanized areas; this will have an effect on the use of technology, and as to which providers can afford or obtain the latest equipment or upgrade that which they have. To the extent some of their more costly procedures are now subsidized by cost reimbursement, they will have little choice between reducing services or profits, either increasing income by insuring a significant number of high reimbursement cases (diagnoses) or discontinuing services.

With specific reference to diagnoses groupings (case mixes) for reimbursement, the carrier (Government or contractual organization such as Blue Cross/Shield) will have little, if any, control over the mix for which payments will be made. Not factored into any studies or conclusions is that treating and admitting physicians will control the case mix by diagnoses. It will be medical personnel, who not only have an interest in their own reimbursement profiles but have an interest in that of the provider, who generally decide the admitting diagnoses groupings. According to material prepared by the Health Care Financing Administration (DRG fact sheet), "Prospective reimbursement based on DRG's is outcome oriented. Hospitals are paid a specific amount for the entire treatment of a patient—it provides incentives to hospitals to develop economies in the management of its overall system for the delivery of health care because the hospital receives one payment for the total care it provides a patient.

Hospitals will not have incentives to deliver less care to any one specific individual, but rather allocate their resources throughout their entire patient population in the most cost-effective fashion".

The assumptions inherent in the above statement and the prospective, rate setting and DRG systems of reimbursement are suspect in that were management inclined to operate in the most cost effective fashion, does each and every facility have the necessary management expertise to do so? If there is the necessary expertise, a definition of "most cost effective fashion" has not been given. There has been no cost benefit analysis done in which the level and quality of health care provided the population is equated to reductions in reimbursement. Whether such an analysis could be made is questionable, so the question reverts to whether access to health care by those who cannot pay will be available when needed. To some extent that has already been answered in the negative. In the final analysis, the various cost containment systems may well result in a two (or three) tier health system in which those who must rely upon Federal, Federal/State programs will "stand in line" for services while those who can pay out of pocket are served along with those whose diagnoses will provide for the highest reimbursement.

In many cases, cost containment will probably result in providers dropping entire groups of services in their less productive cost centers in order to achieve economy even though no such service may be further available to individuals within commuting distance.

With respect to specific problems that affect individuals who are blind or those with low visual acuity, the DRG system for prospective reimbursement would discriminate against many of those who have eye problems that might be alleviated by surgery and other treatments. For example, an individual age 66 with treatable cataracts would probably fall into a lower level reimbursable category and may have treatment delayed while the provider treats those with higher reimbursement factors. However, if the facility removed the cataracts the individual might be productive and need less care of all types whereas, on the other hand, his or her needs for medical care and other services would increase. Generally, since eye problems do not lead to extended hospital bed usage, those in need of such care, without some other "higher level" diagnoses requiring other treatment, will be in line for service or rushed in and out to build up admission rates.

From the user's standpoint, the only beneficial aspect of the prospective payment system proposed by the Department of Health and Human Services is that which provides for total payment to hospitals on behalf of medicare beneficiaries excluding deductible and co-insurance, and the prohibition on the hospitals billing Medicare beneficiaries any cost differences.

Inasmuch as the cost of health care is inextricable from the national economy, we realize that bringing down the cost of care cannot be dealt with in isolation. Attempts to control one segment of the "industry" only cause bulges in other parts or deletion of services. Therefore, we propose a number of near and long term actions rather than one major effort directed at hospitals only.

We propose that the Government provide actual competition to hospitals and medical providers by funding clinics, hospitals and care centers that would provide a full range of services to Medicare patients in house. This would mean contracting with doctors, nurses, hospitals and others instead of paying fees through "plans". This would be especially helpful in large urban areas where some hospitals are closing all or part of their facilities because of for-profit organizations moving in.

Further, the Government should insure programs for training additional doctors, assistants, nurses and aides to increase competition rather than letting the various medical professions decide how many professionals are needed in order to insure high incomes.

The provision of care, not being limited to hospitals, should be looked at in its totality. In many cases, increased personnel and numbers of nursing home beds would relieve doctors and hospitals of expensive care if there were sufficient facilities and proper care. If the nursing homes were in sufficient supply and properly staffed, much of the medical care provided in hospitals could be provided at a lesser cost in the nursing homes if a sufficient number of doctors, nurses and aides were on duty. As it is now, a skilled nursing facility receives medicare reimbursement for a limited time only, and only for providing specific nursing services and therapies. Medicare could be extended to services of a medical and nursing nature for indefinite periods and keep the patients out of the hospitals. Also, encouragement and assistance should be given to the building of nursing care facilities in areas where such services are in short supply. In some of the smaller towns and in rural areas, the facilities have long waiting lists which extend some hospital stays. Again, it is both personnel and facilities that are needed.

Inasmuch as prospective payment systems have not shown themselves as encouraging high quality full services, it should only be used as one or a variety of effects. For one thing, it should be fully tested under strict controls to insure its efficacy, and it should be tested across the medical care spectrum, not just hospitals.

STATEMENT ON BEHALF OF THE AMERICAN MEDICAL PEER REVIEW ASSOCIATION PRESENTED BY HOWARD STRAWCUTTER, M.D., PRESIDENT

Mr. Chairman, I am Howard Strawcutter, M.D., president of AMPRA and a practicing physician in Lumberton, North Carolina. The American Medical Peer Review Association (AMPRA) includes 137 organizations across the United States. These physician-led organizations provide utilization and quality review services to private and public health insurers, employers and other entities which provide or pay for health care service. More than 100,000 physicians are members of these organizations, representing the full range of medical specialties and practice settings.

AMPRA is the successor organization to the American Association of Professional Standards Review Organizations (AAPSRO). AMPRA fully supported and continues to support the Peer Review Organization provisions of the Tax Equity and Fiscal Responsibility Act (TEFRA) authored by you and Senator Baucus last year. Those amendments made substantial improvements in the system for assuring effective utilization and quality review of the care provided to Medicare and Medicaid patients and provided a significant stimulus for similar review activities in the private sector. Our organization appreciates very much the strong support of this Committee for independent, professional review of medical care. We pledge to continue our efforts to improve the quality and appropriateness of care provided to all patients and to work cooperatively with you toward our shared goals.

As you know, under prior law, PSROs were directed to concentrate their activities, as a first priority, on monitoring hospital admissions and lengths of stay on a concurrent basis. PSROs had considerable success in accomplishing those objectives.

Examples of that success are reflected in the 1981 AMPRA report on PSRO impact which shows that:

Twenty-two PSROs reduced Medicare and Medicaid average length of stay resulting in a decrease of 504,359 days for savings of almost $41 million.

Sixteen PSROs reported they saved 113,945 days by reducing days of care per thousand for Medicare and Medicard resulting in savings of over $9 million.

The American Red Cross Blood Services covering West Virginia reports a decrease in blood wastage from 10 percent to 6.7 percent following a study conducted by the PSRO resulting in savings of $62,868.

The PSRO in Milwaukee achieved a 33 percent reduction in the number of repeat x-rays for an estimated cost savings of more than 1.2 million.

PSROs also reported identifying and correcting utilization and quality problems as follows:

Forty-eight PSRO's reported correcting 94 problems associated with inappropriate use of ancillary services.

Twenty-eight PSROs reported correcting 83 problems in long-term care facilities.

Five PSROs reported 11 improvements in the delivery of ambulatory care services.

Nine PSROs reported reductions in numbers of admissions to hospitals.

Seven PSROs reported reductions in admissions/1,000 Medicare or Medicaid beneficiaries.

As long as Medicare reimbursed hospitals primarily on a retrospective reasonable cost basis, the longer a patient stayed in the hospital and the more services provided, the more the hospital was paid. It was quite appropriate under these circumstances for the utilization review process to concentrate to a great degree on monitoring lengths of hospital stays in order to counter these fiscal incentives.

In the determination of how this monitoring should be carried out it was apparent that there was an inherent conflict of interest in hospitals reviewing their own activities with the purpose of reducing their revenues. Futhermore, reviews by agents of Medicare were viewed as suspect on three grounds: first, on grounds that they might be excessively concerned about cost and insufficiently concerned with quality; second, that these agents could not marshall the professional expertise needed to perform the reviews properly; and third, the conflict of interest inherent in a situation where such agents need to maintain the goodwill of the providers of care in their private business. Independent professional peer review presented a mechanism which would not suffer from these problems and would be of sufficient scope to take advantage of economies of scale.

Under the new hospital reimbursement system established by TEFRA and the proposed DRG-based payment plan recommended by the Administration, the financial incentives for hospitals change. For one thing, these systems pay on the basis of hospital stays rather than on the basis of per diem costs for routine services. Under TEFRA and even more under a DRG-based prospective payment system, hospitals, can profit not only by increasing efficiency—the goal—but also in ways unintended by policy makers. These inappropriate ways include:

(1) admitting patients who might be cared for on an outpatient basis;

(2) the favoring admission of patients within each DRG whose costs are comparatively low and stays brief;

(3) allowing bias to affect the selection of principal diagnosis for a patient with multiple diagnoses in order to obtain higher payments; and

(4) withholding clinical services or substituting less expensive services, or delaying use of new technologies in order to reduce the cost from the point of view of the single stay, but possibly inducing greater overall use of services and greater aggregate costs when subsequent stays and services are required.

Mr. Chairman, we are seriously concerned about the potential for any or all of the foregoing responses to occur as a result of the changed financial incentives associated with the TEFRA payment system and with DRG-based prospective reimbursement. Our anxiety is heightened by the Administration's apparent total disregard for any system to monitor the quality and appropriateness of medical care as evidenced in their recommendation to repeal both the PRO statute and the utilization review requirements under Medicare and Medicaid. We do not share the Administration's view that functions performed by PROs or PSROs can be most effectively provided through contracts with fiscal intermediaries. Our experience confirms the fact that peer review, if it is to be effective, must be carried out with the skill of professionals, by physicians in active practice organized at the local level.

We believe the issues involved in quality reviews under DRGs will be more difficult than ever before. For example, if a DRG is established, as proposed, for hospital admissions for pneumonia, there must be an effort made to provide assurance that hospitals are not induced to admit some of the many pneumonia patients now treated properly as outpatients. Furthermore, when there is a financial incentive to reduce the hospital's quantity of services, there must also be an effort to protect the patients against their receiving inadequate care. Such behavior could result in multiple readmissions, possibly at higher aggregate cost. Minimizing cost during a hospital stay is not the objective we seek. Maximizing the cost-effectiveness of care in the aggregate and reducing aggregate costs are the appropriate objectives. These goals require the use of the expertise of professionals in the surveillance of medical practice and in obtaining the cooperation of providers of services in maintaining appropriate standards of practice.

In order to assure that hospitals do not enrich themselves inappropriately by taking advantage of loopholes in the rules of the new Medicare payment game, an effect utilization and quality review system must continue to operate to monitor the hospital's admission practices, its provision of care and diagnostic coding, to conduct evaluations of patient care outcomes, and to initiate corrective actions as necessary. This is the purpose of the PRO law and we urge you to direct the Department of HHS to proceed with the implementation of this law in a timely manner.

The HHS report recommending the adoption of a DRG approach to prospective reimbursement indicates the intention to use PROs in the operation of the DRG payment system. During the implementation phase the report states on page 61 that, "amendments to Peer Review Organization contracts" will be made. Unfortunately, we have been unable to reconcile this position with the recommendation contained in the Administration's FY 1984 budget which calls for the repeal of the PRO law. We urge that you continue to support PROs and take such steps as may be necessary to assure the prompt and reasonable implementation of this law by the Department of HHS.

As you know, Mr. Chairman, members of our Association in the State of New Jersey have been actively involved with the DRG experiment in operation there. You have heard testimony from them and others in New Jersey about the vital importance of this effort to the success of that experiment to date. Our members in other states are prepared to offer the same assistance to Medicare and its beneficiaries so that quality of care and the integrity of the payment system are maintained.

Our members are uniquely qualified to perform the functions required to assure proper medical practices under prospective reimbursement and are anxious to assist in the transition to a more equitable and economical payment system. At the same time we are expanding our review activities through private contracts with insurers, employers and others in the private sector who recognize that broadly-based, community wide quality review programs are key to the promotion of quality and to cost-effective medical care.

STATEMENT OF THE AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION PRESENTED BY MARTIN A. WALL, DIRECTOR OF GOVERNMENT RELATIONS

INTRODUCTION

It is a pleasure to submit this statement to you on behalf of the American Osteopathic Hospital Association (AOHA), the national organization representing the more than 200 osteopathic hospitals spread across 31 states. Our Association Headquarters is in Arlington Heights, Illinois, with an office in Washington, D.C.

OSTEOPATHIC HOSPITAL PROFILE

Our members serve as the primary institutional care facilities for those individual consumers who choose to receive their health care from one of the nearly 20,000 practicing osteopathic physicians in the nation. Osteopathic hospitals have nearly 25,000 beds available and last year treated over 800,000 inpatients and 3,000,000 outpatients.

Many of our hospitals are located in rural and semi-rural areas and all osteopathic hospitals have an historic and philosophical commitment to providing comprehensive, quality health services to people. Nearly half of our hospitals have less than 100 beds and over 80 percent have less than 200 beds, reflecting our special community orientation. Nearly 85 percent of all osteopathic physicians are primary care practitioners and more than half practice in communities of less than 50,000 persons.

Osteopathic hospitals are also dedicated to medical education. All of our hospitals with 200-299 beds are teaching institutions, while 70 percent with 100–199 beds have teaching programs. These programs produce general practitioners, an identified need of our nation's medical manpower resources.

In addition, our hospitals have had a long, historic tradition of providing the type of innovative community health care service advocated in recent years by the federal government. Our institutions and profession stress wellness and preventive care resulting in a "patient oriented" approach to medical care. The profession is founded in the philosophy of treating the whole person, not just the symptom or disease, because what happens in one part of the body can affect other parts. Wholistic care, family medicine, primary care, and a humanistic "hands-on" approach to treatment have been the hallmarks of the osteopathic profession for over 100 years. The AOHA is proud that our hospitals have been at the cutting edge of these progressive movements within the health care delivery system. With this backdrop, it is our pleasure to convey to the Committee our thoughts on the move toward prospective payment for hospitals and to offer specific policy recommendations for your consideration.

AOHA'S COMMITMENT TO PROSPECTIVE PAYMENT

The American Osteopathic Hospital Association has long recognized the necessity to move away from the retroactive cost-based payment system and toward a prospective mechanism with meaningful incentives. As far back as 1977, we forcefully communicated our position to the then Secretary of the Department of Health, Education and Welfare, Joseph Califano. We conveyed our long held view that a vital need existed to "develop new payment mechanisms that will encourage efficient managment of our resources and contain rising costs without impairing the capacity of the health care system to meet our patients' needs."

Our long support for a move from cost-based reimbursement and toward prospective payment was reiterated by AOHA's Board of Trustees in 1978. Our Board was convinced, even then, that retroactive reimbursement was inherently flawed because: it failed to consider the provider's full financial requirements; it lacked any incentive for efficiency; it did not consider the true nature of hospitals costs; and it kept intact barriers to those who cannot afford to pay for care. The problems our Board cited five years ago are even more acute today as witnessed by the continual chipping away of reimbursement through tight retrospective payment controls. Thus, encouraged by the developing consensus emerging within the hospital field and within government, AOHA restated its endorsement of the concept of a prospective fixed-price payment system for hospitals this past May and during the ensuing months fleshed out a series of policy principles.

PROGRESS TOWARD PROSPECTIVE PAYMENT

New and different public policy concepts often take years, if ever, to reach the consensus stage. Activity within the past year reveals encouraging signs that the prospective concept has reached that significant plateau.

Action taken by the Congress through the Tax Equity and Fiscal Responsibility Act of 1982 to require the Department of Health and Human Services (DHHS) to submit a prospective plan to the Congress by December 31, 1982, is clear recognition of the support for prospective payment within Congress. The "fast track" the issue is now on further signifies its urgency. AOHA pledges to work in concert with this and other health committees, DHHS and others to develop a workable and equitable program.

QUESTIONS CONCERNING PROSPECTIVE PAYMENT

A number of important, unresolved policy questions have emerged from our Association's deliberations and the national debate on prospective payment. For example, should we have a single national approach and/or payment methodology or allow states the option to tailor their own programs according to local circumstances? On what basis should payment be set? Should be hospitals be included?

What services should be under the prospective rate? For example, should both impatient and outpatient services be covered or should we begin incrementally by limiting the plan to inpatient? How will teaching costs be handled? How will capital needs be recognized? How can the demand for health services on the part of consumers be addressed? These and other questions have been discussed by AOHA and others and need to be fully aired.

ELEMENTS OF A PROSPECTIVE PAYMENT PROGRAM

In our view, the DHHS plan is a constructive first step toward a Medicare-only prospective payment program. In particular we support its recognition of the need to consider separately medical education and capital costs.

RECOGNITION OF TEACHING COSTS

This overriding element, in our view, is the essential requirement that any prospective payment approach must include.

As I previously mentioned, osteopathic institutions are unique in that more than half of our hospitals have teaching programs. Interns and residents from 15 osteopathic medical schools train in our institutions. But what really distinguishes our teaching institutions from the non-osteopathic teaching hospital model is that the overwhelming majority of our teaching hospitals are community facilities. I think it is worth repeating that 70 percent of osteopathic hospitals with 100-199 beds are teaching facilities while all of our hospitals with more than 200 beds have medical education programs. Thus, any prospective payment plan must recognize and take into account the costs associated with the osteopathic, community teaching hospital when compared with costs in the non-teaching hospital. In any peer group assignment, the osteopathic teaching hospital will be at a severe competitive and financial disadvantage unless this unique circumstance is recognized through a pass-through for teaching costs. If this is not accomplished, there will be no encouragement for osteopathic institutions to maintain their extensive medical education programs which would have the effect of thwarting the admirable federal health policy objective of training needed primary care physicians, especially those committed to rural health delivery, preventive health care and wellness programs. We are also concerned about how DHHS would calculate the lump sum indirect medical education costs.

Capital costs

In addressing the capital question we are pleased that DHHS has recognized the need to treat such costs separately. We reject the argument that a pass-through will lead to an explosion of hospital construction. State certificate-of-need laws, financial market conditions, capital availability and other factors provide the necessary checks.

Prospectively determined prices for inpatient and outpatient services

While DHHS has proposed an inpatient only prospective payment system, osteopathic hospitals support determining outpatient rates also on a prospective basis. Although the Department argues that a methodology does not exist to achieve this, we suggest paying hospitals for outpatient services on the basis of usual, customary and reasonable charges. Inclusion of outpatient services in the prospective system will prevent cost shifting to those services while also reducing reporting burdens for hospitals.

Basis of payment and pricing for inpatient services

AOHA recognizes the political reality of a discharge based DRG specific price as the unit of payment. However, we are concerned about mandating a single national average price. We recommend offering a hospital the option of accepting a regional average price or a 3 year phase-in composite price based on: 2/3 of the hospitals own specific costs and 1/3 the regional average price during the first year, 1/3 of the hospital's own cost and 2/3 of the regional average during the second year and, a 100 percent regional average price during the third year.

Regional groupings should be carefully configured to reflect similar hospital experiences.

The price should also include a legislatively mandated price adjustment for inflation and technology and should financially recognize hospitals that serve high volumes of Medicare and/or low beneficiaries. In the case of newly constructed hospitals or replacement facilities, AOHA recommends negotiating with a fiscal intermediary the initial year's price.

Assignment/non assignment

AOHA believes in an expanded role for the consumer in making decisions about the type of health care services he or she desires to purchase.

We have also held the position for many years that Medicare has the responsibility to meet hospitals full financial requirements. Therefore, while our members support providing incentives for individual institutions to accept the DRG price, we feel that the hospital should also be provided with the option of seeking a broader financial participation by the beneficiary. For example, if a hospital decided to elect the non assignment option, beneficiaries would be notified in advance that they may be required to pay an additional amount for services rendered. Those charges would be publicly disclosed and filed with the intermediary. Thus, the consumer would be fully aware of the hospital's pricing system and would be more involved and sensitive to cost issues. Demand would be affected and "consumer choice" would be incorporated into the prospective payment system.

Special consideration for small and rural hospitals

Since almost half of our hospitals have less than 100 beds and a number are located in rural or semi-rural communities, we are concerned that the often volatile changes in case mix and volume of admissions that such hospitals experience should be taken into consideration under a prospective payment system. While we support a program covering such institutions, we recommend that an adjustment factor be built into the prospective system for the small and rural facility. This would assist such hospitals in making a transition from the current reimbursement system to a prospective program.

Exceptions and appeals process

It is our conclusion that an exceptions and appeals process is essential for a program that is not perfected and lacks experience on a national basis. AOHA supports limiting the exceptions criteria to such factors as the special needs of sole community providers, unusual shifts in the inflation index, unexpected changes in the severity of illness within a hospital's case mix, questionable actions by the administrative body implementing the program, and computation errors.

A system of judicial review also needs to be part of the prospective system. This appeal mechanism should be an independent third party.

Waiver authority

AOHA strongly favors encouraging states to develop locally tailored alternative and innovative reimbursement mechanisms. This is especially important since the DRG system has not been tested on a national basis. Reimbursement methodologies and knowledge are changing rapidly and while we recognize the necessity to move now to an agreed upon prospective approach, Congress should not stifle experimentation and creativity.

This is especially relevant in osteopathic hospitals. While DRGs may be a political reality, we must be concerned about whether the practice patterns of osteopathic physicians, which differ from allopathic physicians' patterns, would be reflected in a DRG system. Case mix variations in our rural and urban hospitals, our teaching and non teaching institutions, as well as possible overall case mix differences between osteopathic and allopathic hospitals need to be carefully examined. AOHA hopes to be able to further document these concerns in the future by examing the historical experience of a sample of our institutions. Providing a waiver and demonstration authority would also help provide some answers to these questions.

Utilization control

Utilization review becomes particularly important for hospitals under a DRG based system. We would recommend exemption from external utilization review for a hospital with a effective internal control program. Under this approach, the federal government would grant "deemed status" to institutions meeting the criteria. Others would be denied payment in cases where it was concluded that admissions were inappropriate or medically unnecessary.

Sunset provision

Philosophically and politically, AOHA believes it makes common sense for a significantly new approach to reimbursement such as we are proposing to be reevaluated comprehensively after a reasonable amount of time. Thus, we would recommend that any prospective payment plan include a "sunset" provision preferably after a 5 year period.

CONCLUSION

Prospective payment is different things to different individuals and groups. During this fast moving legislative debate differences in specific approaches have surfaced and a consensus on details will be harder to reach. We have seen this occur through the years with other policy initiatives and worry that this might happen again with prospective payment. Osteopathic hospitals do not want to see the momentum lost. While we fully recognize that prospective payment is not a panacea for the complex health care problems we face, it is a step toward common sense and equity in federal hospital payment policy.

We thank you for the opportunity to submit our views to you today and pledge our cooperation in working with you in developing a equitable prospective payment system under Medicare.

CALIFORNIA HOSPITAL ASSOCIATION,
Sacramento, Calif., February 25, 1983.

Hon. ANDREW JACOBS, Jr.,
Chairman, Health Subcommittee, Committee on Ways and Means, Washington, D.C.

DEAR CONGRESSMAN JACOBS: The California Hospital Association respectfully submits the following statement for the record of the hearing on Medicare hospital prospective payment system proposal by the Administration.

On behalf of its more than 530 institutional members, the California Hospital Association (CHA) supports a Medicare hospital-based, per case, prospective pricing system with adjustments for changes in input prices and intensity, If the new system is designed and operated equitably, hospitals will no longer face the uncertainty and potentially severe economic dislocation of the present reimbursement system, in which arbitrary cuts are made annually and unfairly distributed among institutional providers. California's hospitals have consistently had a disproportionate share of the payment penalties: Current reimbursement limits will penalize U.S. hospitals by over $2 billion; $276 million will be assessed against California hospitals.

To be equitable, the prospective system must include at least the following:

(1) Medicare beneficiaries should have the right to select an appropriate level of care; if Medicare does not pay the costs of the delivered services, providers should, up to a limit, be able to bill patients for the difference.

There are today and for the foreseeable future insufficient public funds to sustain the mainstream level of care to which our society has become accustomed.

For years hospitals could shift the unreimbursed costs of treating Medicare and Medicaid beneficiaries to the private patients. Thus, the indirect subsidy of the government's beneficiaries by the private sector, has allowed a uniform level of care in communities. However, due to the continuing escalation of private insurance premiums (in excess of 30 percent over the last few years), the private sector, at least in California, will no longer accept this cost shift. Without any other source of funding support for the Medicare and Medicaid payment shortfalls, hospitals will have no choice but to adjust the level of hospital services and distribution of resources to the respective program's payment level. Eventually, there will be multiple levels of care.

All patients have a right to select the appropriate level of care they feel they need. This is certainly true in the private sector, where patients know that if part or all of their treatment is not covered by their insurance plan, they in turn would pay the difference. If market forces, resulting from restricted government payments, force hospitals to limit available Medicare services, then beneficiaries should have the right to request and receive additional services, and, as in the private sector, pay for these services out-of-pocket or through some supplemental insurance coverage. We view this as a pragmatic response as health care delivery and financing system evolves from a social system to an economic system. The alternative is, despite the best intentions, increasingly forcing Medicare beneficiaries into a different and more restrictive health care delivery system than that available to the general community. Let us hasten to add, hospitals will resist this development as long as their financial resources and community support will allow.

(2) The DRG rates should be set at a level that would, in sum, achieve the same level of savings as would have been reached by the current reimbursement limits and target rate established by the Tax Equity and Fiscal Responsibility Act of 1982. This overall level is approximately 108 percent of the national average.

(3) The initial rates should be based on a hospital's own costs at the time it enters the new program. Recognizing local differences in the cost of goods and services pur-

chased by hospitals will solve numerous problems caused by an inadequate data base and, we feel, fallacious methodological assumptions. For example, HHS assumes that the method used to define a hospital's case mix and establish its payment rate, i.e., diagnostic related groups (DRGs), represents medically meaningful and homogeneous groupings; experience in New Jersey has shown the opposite: the groups are not medically meaningful and are heterogeneous.

If regional or national grouping standards are adopted, adjustments should be made for local labor and non-labor costs. The current wage index should be revised to differentiate between full and part-time employees and between different categories of employees. In some California SMSAs, totally unrealistic differentials are caused by including the salaries of physicians and other highly paid health professionals employed by three very large state hospitals. The use of Medicare cost report data could correct some of these problems.

CHA urges Congress to direct the development of an appropriate variable that adjusts the wage index to reflect regional differences in the cost of employee fringe benefits. While the current wage index is applied to these costs, it does not include any information on the regional costs of fringe benefits.

(4) The prospective pricing system should fully recognize the impact on operating costs of the hospital's approved scope of services, its patient mix and the intensity of care required. One way to partially address this problem area is to continue to group hospitals based on bed size and hospital location.

(5) Hospitals must, at least, have the same rights to judicial, as well as administrative reviews, as they have under the current reimbursement system. Further, during the new programs' first two years, there should be a process to expedite reviews, especially of decisions which determine the rates of payment.

Hospitals should also have timely access to a flexible exception process for unique circumstances in which patient care may be affected.

Psychiatric, pediatric and long-term care hospitals should be exempted from the prospective payment system, as should sole-community providers and hospitals of less than 50 beds.

(6) Annual price adjustments should be implemented according to a Congressionally mandated formula. This inflation rate adjustment should recognize hospital-specific inflation, effective technological improvements and intensity, where needed, to assure quality of service.

The emphasis on new technologies and intensity of service reflects CHA's conclusion that current reimbursement limits use a very arbitrary and inadequate adjustment for intensity.

(7) Education and capital costs should continue to be separately reimbursed on a cost basis. These "pass throughs" recognize that teaching hospitals incur added costs, and that physical plant and major equipment expenses reflect decisions, interest rates, and other factors of prior years.

(8) The data base must reflect accurate patient care and financial information in each hospital. The best data base available has been developed from three year old Medicare cost reports, using a highly suspect and often criticized methodology. Intensive efforts are needed to upgrade the government's data collection and processing capability. And the government's data base used to calculate the Medicare prospective price schedule per case should be updated at least once every five years.

All data files should be available to hospitals so that accuracy can be verified.

(9) State waivers should be available for alternative system. The key performance criterion should be that the state system achieves a Medicare spending rate at least equal to, or less than, the national rate. State waivers should encourage all types of approaches, not just those based on DRGs.

We appreciate this opportunity to provide our comments and concerns regarding a Medicare prospective pricing system for hospitals. As with any major change in hospital reimbursement, we are particularly sensitive to the equity of the proposed system and the fairness of its implementation. CHA cannot support the Administration's proposal as submitted—the risk to the financial stability of our hospitals is just too great. However, CHA does support prospective pricing proposals which recognize and reflect equitably the issues raised by our member institutions.

We are prepared to discuss these and any other issues. Please do not hesitate to contact us if we can be of any help.

Respectfully,

PAUL D. WARD, *President.*

STATEMENT OF ROBERT E. PATRICELLI, EXECUTIVE VICE PRESIDENT, CIGNA CORP.

CIGNA Corporation is the second largest stockholder-owned insurance company in the United States, with assets of $32 billion. It is also one of the largest health insurers in the country, the largest investor-owner of health maintenance organizations with over 680,000 people enrolled, the largest investor-owned provider or rehabilitation services, and the former owner or manager of over 150 hospitals. Because of this large and diverse commitment in the health care field, CIGNA brings a unique perspective to the subject of hospital prospective payment systems.

CIGNA supports the efforts of this Committee, the Congress and the Administration to develop and encourage propective hospital payment systems. Prospective payment has been demonstrated to be an effective way to contain hospital costs while maintaining the quality of care. Since a true prospective payment system puts hospitals "at risk" for their management decisions, widespread use of prospective payment is an essential first step in reintroducing the laws of supply and demand into the health care delivery system. CIGNA believes that over the long term, competition should can can supplement and largely replace regulation as a means of controlling the rising cost of health care.

With this objective in mind, CIGNA had developed a model prospective payment proposal with the help of experts from the hospital and insurance industries, the legal and accounting professions and the investment community. This system relies on competitive incentives to encourage the cost efficient delivery of care. In addition, it builds upon the proposed Medicare plan before this Committee and offers an integrated and long-term solution to our health care financing problems.

Before describing the CIGNA proposal, I would like to reinforce the main points made by the Health Insurance Association of America in its testimony before the Committee regarding the Department of Health and Human Services' prospective payment proposal. The Department's proposal will not accomplish its cost containment objectives because it applies only to Medicare beneficiaries. A hospital payment system must apply to all patients so that hospitals face consistent incentives from the payors of care. A Medicare-only system encourages cost accounting manipulations rather than an integrated cost containment strategy. As a result, it creates incentives to shift costs rather than contain them. Some members of the hospital community have suggested that all payor systems are equivalent to rate-setting programs. The proposal, which I will describe, clearly indicates that this need not be the case.

CIGNA also believes that the Congress should encourage the development of state-level prospective payment systems. This approach affords experimentation with innovative approaches to a complex problem and permits tailor-made solutions to regional differences. Furthermore, existing state programs have clearly demonstrated that they reduce the rate of growth in hospital expenditures for all patients, including Medicare, while maintaining the quality of care.

CIGNA PROPOSAL

The CIGNA prospective payment hospital builds upon pricing and selling practices used in most industries. While a complete description of this proposal is included in the attached appendix, the essential features of the plan are:

Purchasers are encouraged to consider finances in the selection of care

Purchasers of care, including physicians, third parties and consumers, will be able to shop for hospital care by comparing prices for Diagnosis Related Groups (DRG) provided at different hospitals. The DRG price at each institution will be available to the patients and those acting in their behalf in advance of treatment.

All usual expenses of doing business are recognized

Hospitals will establish their own prices for their Diagnosis Related Groups and will not be subject to rate-setting controls in a price competitive environment. They will be able to include all usual business expenses in their DRG prices. However, the basic pricing structure will normally have to be adjusted for certain hospitals that have explicit public responsibilities. Most hospitals will find that these initiatives, such as teaching and uncompensated care costs, must be financed separately from the general payment system to maintain a competitive pricing structure.

Prices for services will be widely disclosed

Hospitals will have to make their DRG prices available to the public to facilitate interhospital comparisons. Hospitals will also participate in joint public/private sector utilization review programs to assure the optimal use of resources and the provision of quality care.

Discrimination in prices is avoided

While hospitals will be required to avoid discriminatory pricing practices, negotiation of special prices reflecting payor practices that result in savings to the hospital for their patients will be allowed. Therefore, not all payors will pay the same price. Criteria for special pricing considerations may be developed by each hospital, but must be equally available to all payors.

All patients are included

The payment system will be applicable to all patients, irrespective of the source of payment or insurance coverage, with special consideration for patients not included in third-party payment groups.

Profit and loss or the retention of surplus are permitted

The payment system will make hospitals financially responsible for their decisions by allowing profitable hospitals to retain surpluses and for others to incur losses, regardless of tax status.

Effective accounting, auditing and reporting practices are used

The payment system must minimize accounting, auditing and reporting requirements. Hospital financial reports must contain sufficient information to allow payors to compare hospital performance.

Implementation is phased-in

The payment system must be phased-in to allow adequate time for appropriate participation by patients, providers and payors.

State programs are encouraged

The Congress should provide incentives for states to experiment with competitive pricing systems. This experimentation will allow prospective payment systems to meet the special needs of each state and to refine the competitive pricing approach.

ESTABLISHING THE NEW PAYMENT SYSTEM

The proposed payment system described above requires meaningful change by all participants in the health care field, including hospitals, practitioners, patients and insurers. In some instances, legislative initiatives will be needed to accomplish these changes. Some of the legislative provisions include: Establishing incentives for states to develop all-patient prospective payment systems; disclosing by hospitals of DRG-specific price and utilization data for all patients; requiring cost sharing in health insurance plans; creating a special means to finance teaching and uncompensated care costs; and prohibiting unfair discrimination in hospital prices.

We believe that the Medicare prospective payment legislation can and should anticipate longer term reform of the entire payment system. A proposed approach and timetable is set forth on pages 7–8 of our attached proposal. We would be pleased to work with you and your Committee to develop specific legislative language to incorporate some or all of our suggestions into the current legislation.

SUMMARY

The payment system described here would be created by a minimum of regulation and would allow hospitals to operate more like other economic enterprises. It includes basic marketplace procedures and incentives to encourage efficient use of health care resources. It requires gradual but substantial procedural and behavioral changes of all health care participants who must work together to assure that quality care will be provided at an appropriate cost.

This payment system offers advantages to all participants in the health care field. Hospitals and physicians will operate in a system that includes marketplace principles and avoids onerous regulation. Providers will have incentives to consider productivity and resource usage in the provision of care. They will also be able to predict revenues because prices for care would be determined prospectively. Likewise, third-party payors, including government, will be able to examine the prices paid for care on the basis of common and objective data, recommend efficient providers and predict their costs accurately. Third-party payors could evaluate the performance of institutions and providers and adjust their practices to encourage further efficiency. Consumers and those acting in their behalf will be able to make informed choices about the selection of care and will know their payment liability in advance of treatment. Finally, the system will assure the provision of quality care at competitive prices to all public and private sector patients.

[Attachment]

A Competitive Pricing System for Hospital Payment

I. INTRODUCTION

The 97th Congress recently enacted legislation to stringently regulate Medicare payments to hospitals. In addition, they mandated the Department of Health and Human Services to establish a system of prospective reimbursement for Medicare. DHHS has responded by proposing a Diagnosis Related Group (DRG) system which will establish national payment rates. Clearly, the direction is toward an increase in federal regulation of hospital pricing.

Many people believe that over the longer term, competition should supplement regulation in controlling health care spending. In a competitive pricing system, as described here, hospitals identify their products in a comparable fashion, establish their own price for products in advance, and make both product descriptions and prices available to consumers. Patients, physicians, or third party payors acting in their behalf could then shop for care on the basis of price, as well as quality and other consumer preferences. The payment system emphasizes adequate communication of information to assure competitive pricing. An essential element of this system is that the product must be similarly defined across institutions, so consumers have a basis for comparison. Continuing regulation will be required to accomplish this. This system will eliminate the duplicative and costly multiple accounting, audit and review procedures that are presently used because a total hospital product will be compared rather than the individual components such as lab tests, nursing care, room and board. Further efficiencies will be obtained because one system can be applied to all public and private third party payors.

An essential ingredient of this system is that it places the hospitals at economic risk for their business decisions. This prospective system allows for profit or surplus to be accumulated, but does not give institutions assurances of financial solvency. Hospitals would be paid according to their preestablished prices for fixed periods of time and operate within the revenues generated by these prices.

While this system places hospitals at financial risk for their business decisions, it recognizes that certain hospitals also have social responsibilities to deliver charity care, and to perform teaching and research. The costs associated with meeting these public policy objectives could make certain institutions uncompetitive or even financially insolvent. Thus, our system contains safeguards to assure that these costs are covered outside normal payment practices. The system could be used nationally but might be better implemented initially at a state or regional level as long as all patients participated.

II. GENERAL PRINCIPLES OF THE PAYMENT SYSTEM

Nine general principles are embodied in this proposed payment system for hospital care. They are as follows:

A. Purchasers are encouraged to consider finances in the selection of care.
B. Prices for services will be widely disclosed.
C. All usual expenses of doing business are recognized.
D. Discrimination in prices is avoided.
E. All patients are included.
F. Profit and loss or the retention of surplus are permitted.
G. Practices and services designed to meet social objectives desired by the community at large are clearly identified.
H. Effective accounting, auditing, and reporting practices are utilized.
I. Implementation is gradual.

III. DESCRIPTION OF THE HOSPITAL PRODUCT

In this new system, hospitals will establish prices for a given case on the basis of Diagnosis Related Group (DRG). The DRG must, over time, be further refined to more accurately reflect the resources consumed for the treatment of an individual case or discharge. If possible, they should be expanded to cover certain outpatient procedures as well. Hospitals will define their product uniformly but they will be free to decide what to include in the price.

Developing meaningful DRGs will not be easy and the initial effort will not be perfect. Nevertheless, much of the research and development of systems which use DRGs has already taken place. A more refined system is well within the limits of existing knowledge and data collection capabilities of the hospital industry. However, hospitals must be allowed time to create an accurate data base for efficient system operation.

Special Circumstances

The DRG payment system bases price on usual resource consumption and implicitly relies on the statistical "law of average" to assure that payment is equitable. Thus, on the average, the price paid for care consumed in closely related to the hospital's cost to provide care. This system is equitable for payors who represent large groups because cost variations will average out over a large population. However, the system can result in inequitable prices for an individual patient who pays his own bill. His actual use of service could be significantly different from the average for the DRG. Thus, a separate pricing approach must be devised for the relatively few patients who pay their own bills. Fee-for-service type pricing would be adequate for this group.

IV. DESCRIPTION OF PAYMENT METHODOLOGY

This methodology was developed to encourage price competition but gives hospitals with diverse objectives an equal opportunity to attract patients.

A. Setting hospital prices

In the proposed payment system, hospitals will customarily include all normal business expenses in their pricing structure for a "DRG". Although standard product definitions will be presented in the form of DRGs, prices will be set solely by hospitals. Competitive marketplace incentives, influence from consumers and third party payors, and existing antitrust laws will ultimately provide protection against unreasonable and unnecessary price increases in an entire community.

Some hospitals might not have a competitive pricing structure because they have certain expenses, such as medical education, charity care, research and special community services that represent community responsibilities. Provisions must exist so that no hospital is placed in an uncompetitive position solely because it provides services that the community considers socially desirable. These expenses could be included in the DRG price if a hospital desires, but more likely, they will be excluded. They should be identified on the financial statements for the information of the consumer and public recognition of the special role of certain hospitals.

B. Uncompensated care costs

Uncompensated care costs are incurred by those who do not pay their hospital bills and includes both bad debts and charity care costs. In most industries, bad debt is a normal business expense and it would be reasonable to treat hospital expenses in the same manner if the distinction between bad debt and charity care expenses could be made. However, hospitals have found it administratively easier and less expensive to not try in advance to establish whether patients have the resources to meet all of their financial obligations. Therefore, much of what is classified as bad debt would be considered charity care under a more precise definition of terms.

Despite the current lack of clarity in distinguishing between bad debt and charity care, the costs of charity care incurred both on an inpatient and outpatient basis should be excluded from the DRG price because it is a public responsibility. State or local political bodies could determine the level and type of financing for this care. Three approaches are possible: 1) general state-city revenues derived from income or property taxes; 2) special hospital district taxes such as those now used for fire districts, school districts, park districts and the like; and 3) a surcharge on all inpatient care at all hospitals in a given region which would be accumulated in a special fund and used to subsidize institutions with high indigent patients loads. The third approach has recently been enacted into law in both Massachusetts and New York state, and it appears to be a reasonable alternative, but others merit consideration.

C. Teaching costs

There are two types of expenses incurred by teaching hospitals which could make them non-competitive in price.

(1) Direct teaching expenses that can be estimated from hospital accounting data such as salaries, supplies and teaching space.

(2) Indirect education costs that are incurred by teaching hospitals such as productivity losses, extra ancillary services and the like.

The direct costs of educational programs provided in teaching hospitals was estimated at approximately $2 billion in 1980. These costs should be excluded from the DRG price so that teaching hospitals can maintain a competitive pricing structure.

The indirect costs of educational programs provided in teaching hospitals was estimated at approximately $4 billion in 1980. These costs may partially reflect a more severely ill case-mix treatment at teaching hospitals and the need for more highly skilled resources. These costs may also reflect the high quality of care that is provided at these tertiary institutions. At least some of these costs are related to patient care and perhaps should be included in the DRG price.

The appropriate method and level of financing for teaching services must be addressed to maintain the integrity of our teaching facilities. These costs may be financed through a national educational trust, state subsidies, a surcharge on admissions, increases in tuition costs, special taxes, or other methods. We must decide if the level of special funding should include only direct medical education costs or indirect costs as well. Without satisfactory answers to these difficult questions a competition pricing system will be difficult to achieve.

D. Research costs

The costs of sponsored research will probably be excluded from the DRG price and will continue to be financed by the sponsoring agency. Unsponsored research is generally not so large that it could not be included in the DRG price according to each hospital's guidelines as it seeks to maintain a competitive pricing structure.

E. Special community programs costs

Services provided for special community programs, such as a family planning or blood pressure detection plans may be excluded from the price for a DRG. Most hospitals may want to make these programs self-supporting through fees charged to program participants. They could also be financed through a special state or local fund or specific private donations.

F. Capital costs

A competitive pricing system will allow hospitals to accumulate surplus for the purchase and maintenance of plant and equipment. Therefore, there is no need for special treatment of capital and it should be included in the DRG price.

G. Hospital prices to particular payors

Hospitals should not unfairly discriminate in the prices charged to different patients since this inhibits competition in the financing mechanisms. Individuals or third-party payors should continue to negotiate special prices, but an anti-discrimination provision would strengthen the ability of the hospitals to deal with large payors as well as protecting smaller payors. The payment criteria developed by the hospital will have to be applied fairly to all payors at that hospital and should reflect payor practices that save the hospital money.

V. SPECIAL CIRCUMSTANCES—SOLE COMMUNITY PROVIDERS

The number of areas served by sole community providers and the populations residing in these areas is relatively small. The National Center for Health Statistics estimates that only 125 out of a total 720 discrete medical service areas have only one hospital. Likewise, there are 127 medical service areas that have only two hospitals. Thus, 16 percent of the hospitals are sole community providers, but these institutions serve only 3.1 million people or 1.2 percent of the U.S. population. Only 9 million people or 3.4 percent of the total population are served in areas with two hospitals. Hence, most patients are served in areas where a system of hospital price competition can become a reality.

The price competitive system described in this testimony should apply to all hospitals—even sole community providers. It may be necessary for consumers and third-party payors to carefully evaluate the experience of sole community providers and apply pressure more actively to assure equitable pricing practices. While special price controls could be developed for sole community providers, the small number of people affected suggest that this is unnecessary. Incidentally, the same principles apply and the same solutions suggested in situations where only one hospital in an area provides a very specialized service.

VI. FINANCIAL REPORTING

The methodology described does not require the development of a uniform cost accounting and report system. Costs become the internal concern of hospital management and only prices are the concern of third party payors and consumers. Hospitals will however, be required to use a uniform description of their "products" to facilitate price comparison. Many hospitals will develop a more sophisticated cost accounting system than is commonly in use today. However, the accounting system need not be universal and uniform, rather it should be designed to meet the management and internal auditing requirements of the individual hospital.

Hospitals which seek special funding for social services functions, such as educational expenses or charity care, will have to document the amount for which they qualify. Hositals should also publish a supplement to their financial statements which allows analysis of the income and disbursements related to providing the special social service, uncompensated care, teaching and research described above. Interim government guidelines may be necessary but, as quickly as possible, two supplemental schedules to Generally Accepted Accounting Principles (GAAP) would be created for hospital financial reporting (see Schedules A and B). The new guidelines would be developed by American Institute of Certified Public Accountants to accomplish three things:

Define the nature of usual expenses reported in the DRG price and the supplemental activities;

Outline requirements relating to revenues and disbursements including a description of how these should be identified on the hospital financial statement; and

Define the format and content of a hospital's annual statement to include aggregate financial data, supplementary information on social services, and price and utilization data by payor. To allow proper evaluation and comparison, historical data as well as current year figures would be available.

VII. PAYMENT OF CLAIMS

Claims payment and review will be greatly enhanced with the widespread use of the Uniform bill. As DRG becomes the predominant method of payment, the data required for the payment of a claim will be substantially reduced because only patient identifying data, a price and a DRG number will be required. Of course, hospitals and payors would be free to negotiate a variety of payment procedures.

VIII. AUDITING AND REVIEW REQUIREMENTS

A major objective of this system is to minimize the need for regulation of providers and for individual claim and hospital audits. Under the proposed system there would be a number of safeguards for patients, the general public and payors. First, the hospital would publish audited financial reports, like other businesses, that include simple utilization and price data by payor. This would allow identification of changing utilization and price patterns. Second, existing hospital utilization review programs will undoubtedly continue to be developed and refined. Business coalitions and individual employers are insisting on better data to justify costs. In additon to monitoring quality of care, this would allow easier identification of cases where inappropriate utilization of services occurred. Third, any payor who felt discriminated against in the prices charged to its pateints would be able, through the courts, to subpoena hospital records.

In summary, public disclosure of prices and special expenses will allow normal marketplace scrutiny of hospital activity. Since public disclosure of prices is an important part of this audit mechanism, hospitals must be required to publish prices and give public notice of intent to change prices.

IX. ESTABLISHING THE NEW PAYMENT SYSTEM

It is critical that Medicare, as the largest payor, assume a responsible leadership role. It must address the issue of rising health care costs as a national problem not just as a Medicare problem, and assure that interim changes in Medicare reimbursement are consistent with a competitive pricing environment. The payment system discussed in this paper requires changes by all health care participants—hospitals, pracititioners, insurers and consumers. In certain instances, legislative and regulatory initiatives will be needed to accomplish these changes.

Legislative changes

Legislative changes to create the long range system could be accomplished over a five year period. The following legislation is proposed:

Year 1

(1) Establish a Medicare DRG system. Allow Medicare to establish rates for the first three years to accommodate current budget restrictions and to allow full development of the competitive mechanisms.

(2) Require hospitals to maintain and disclose costs and utilization statistics by DRG for all payors. This would be a condition of participation in Medicare and allow an immediate increase in cost containment activity by private payors.

(3) Create incentives for states to develop all payor prospective payment systems, e.g., (a) Increase Medicaid matching funds for state with system that meet target rate of revenue increase; (b) include DRG start up cost in hospital reimbursement rates; (c) provide federal funding for medical education as long as target revenue increase rates are met; (d) provide states with start up money to develop the state's program.

Year 2

(1) Require cost sharing options for both Medicare and private health plans.

Year 3

(1) Create a national or state medical education trust fund or develop other solutions to fund medical education.

(2) Require states to develop statewide program for funding uncompensated care; reduce Medicaid matching fund for states not complying.

(3) Provide for the creation of state pools for uninsurable and high risk individuals and groups to reduce the incidence of uncompensated care.

Year 4

(1) Enact legislation prohibiting unfair discrimination in hospital prices. Non-discrimination would be a condition of Medicare participation.

Year 5

(1) Require all hospitals to use prospective pricing by DRG for all payors. This would be the national residual program only for those states that have not enacted state programs.

X. PROBABLE RESPONSE BY HEALTH SYSTEM PARTICIPANTS

A. Physician response

The argument is frequently raised that utilization and cost decisions are out of the hands of the consumer and third party payors. These decisions are made by the physician and stronger controls on physician prices are required. The DRG system proposed, by definition, will introduce a new dimension of cost consciousness into physician practices. It creates incentives to limit ancillary services and lengths of stay. The internal accounting mechanisms that hospitals will develop to manage more effectively will also help hospital administrators to influence physician practices more directly. When accompanied by effective utilization review, physicians have and will continue to positively respond to factual presentations of how their practices impact cost. Any instantaneous response is not to be expected but physician practice patterns will change as educational efforts increase and comparative information develops.

B. Third-party payor response

The movement toward inclusion of more cost sharing in health benefit plans has already begun in the private sector. The disclosure of price information inherent in this payment system will greatly enhance the development of Preferred Provider Plans. Differing levels of payments or reduced cost sharing at lower cost institutions will become more prevalent in most insurance programs. The development of plans that pay fixed rates are likely to reappear.

C. Hospital response

The response from the hospital industry is likely to be varied and will probably be related to their current practices, financial situation, and the population they serve. In the longterm, this prospective pricing proposal will result in a more cost efficient delivery of quality services. Hospitals will more directly compete for patients and have greater responsibilty for the behavior of their attending physicians. However, as the system is being implemented, it is essential that hospitals be given sufficent time and resources to make the necessary changes to prevent undue hardships for both hospitals and consumers.

D. Consumer response

Most consumers currently have insurance coverage that protects them for the full financial burden of their health care decisions. As insurance policies include more hospital cost sharing features and preferred provider options, consumers will become more cost conscious in the selection and use of services. In most instances, however, the physician and insurer will still assume a major role in the selection of services. Some consumers will directly respond to the financial incentives in the system, but this requires the widespread availability of price and quality information.

XI. SUMMARY

The payment system described would be created by a minimum of legislation and would allow hospitals to operate more like other economic enterprises. It includes basic marketplace procedures and incentives to encourage efficient use of health care resources. It requires gradual but substantial procedural and behavioral changes of all health care participants who must work together to assure that quality care will be provided at an appropriate cost.

As legislation is developed to move Medicare to a prospective payment system, we would stongly urge the Committee to consider the longer term needs of all consumers and the impact of the legislation on the private sector financing mechanisms. We believe that the principles outlined in this testimony form a good basis for the development of truly responsible legislation.

STATEMENT OF THE HOSPITAL ASSOCIATION OF NEW YORK STATE

The Hospital Association of New York State (HANYS) represents 350 voluntary and public hospitals and residential health care facilities.

Our Association has long advocated the establishment of a prospective payment system for Medicare. We believe such a system would promote economic efficiency, stability and long range planning within the hospital sector.

Following three years of development, and with the approval of the Secretary of Health and Human Services through the granting of a Medicare waiver, New York's Prospective Hospital Reimbursement Methodology (NYPHRM)—a restructured inpatient financing system—was implemented in New York State for the period January 1, 1983 to December 31, 1985. NYPHRM represents the most profound change for the health care industry of our State since the Cost Control Act of 1969, which resulted in the development of the reimbursement system as we now know it. It also represents the culmination of efforts by interested parties to create a stable hospital financing system for the State of New York. While we do not necessarily believe that our system should be a model for national implementation, we believe that a general overview of NYPHRM, and the prior experiences which led to it, would be beneficial to the Committee as it continues its deliberations on the issue at hand.

GENERAL OVERVIEW

Prior to NYPHRM, hospitals within New York State had been paid for inpatient services under several different reimbursement methodologies.

For payment of services provided to Medicare beneficiaries, the federal government used a retrospective reimbursement methodology where hospital reimbursement was determined on the basis of services already provided. Rates paid by Blue Cross, Medicaid, Worker's Compensation and No-Fault Insurance were calculated under differing prospective reimbursement systems where hospital rates were set before services were provided based on the hospital's historical cost experience adjusted for inflation. Under the new system, hospitals will be reimbursed for inpatient services provided by all payors on the basis of a uniform State developed prospective reimbursement system. In 1984 and 1985 all payors are affected by the system through the computation of a prospective inpatient revenue cap which places an overall limitation on hospital inpatient revenues. Once prospectively established, the revenue cap may be adjusted only to reflect major changes in volume, service intensity, expansion and operations. For hospitals this new methodology will mean stable and predictable finances for the first time in 15 years.

At the same time, under the new system, all payors will participate in the financing of at least part of the costs hospitals incur through bad debts and charity care. Payors will also provide an allowance to aid financially distressed hospitals.

BASIC PRINCIPLES

Uniform prospective methodology

Hospital's reimbursement rates from major third party payors will be set under a uniform prospective system. This will help eliminate the conflict caused by differing reimbursement procedures and enable hospitals to project, with a greater degree of certainty, their revenues during 1984 and 1985.

Revenue cap

Reimbursement to hospitals under NYPHRM will be based on the same fundamental concepts throughout the three years of the program. 1983 rates for hospitals will be calculated using each facility's 1981 allowable costs trended forward for inflation. Hospital revenues for 1984 and 1985 will use revenues set in 1983 (still based essentially on 1981 costs) trended forward for inflation and adjusted for the "phase-in" components of the new system. The revenue cap will be adjusted only to accommodate major changes in case mix, expansion, volume or other cost influencing changes in operations. An independent panel of economists will determine the inflation factor to be applied from 1981 to 1983, as well as in 1984 and 1985.

Bad debt and charity care allowance

A significant feature of NYPHRM is a methodology developed to provide revenues to hospitals for costs incurred in providing care to the poor and uninsured. Under NYPHRM, funds are created in regional pools for distribution to hospitals on the basis of hospital-specific need. All payors will participate proportionately in the creation of the pools, with the size of each regional pool determined by regional need. Throughout the State, the total bad debt and charity care allowance to be available is 2% of total statewide reimbursable costs in 1983, 3% in 1984 and 4% in 1985. Those funds in each regional pool will be distributed only within that region.

Discretionary allowance

Each facility will receive a 1% discretionary allowance added to its reimbursement rate each year to retire short term debt, to further offset bad debt and charity care, or to be used for any other purpose, at the discretion of the facility's governing board. Additional monies under this allowance will be available to hospitals subject to criteria to be established regarding the utilization of the monies.

Financially distressed hospital pools

Regional pools to aid financially distressed hospitals with equal ⅓ of 1 percent of each voluntary and proprietary hospital's reimbursment rate. Access to these pools is limited to voluntary and proprietary hospitals lacking the resources to continue caring for the medically indigent. Guidelines governing access to these monies will be established by the New York State Hospital Review and Planning Council.

Transitional funds

Regional transitional funds will equal ¼ of 1 percent of each voluntary and proprietary hospital's reimbursement rates to aid those facilities that are negatively impacted by the implementation of NYPHRM. Guidelines to govern the distribution of these monies will also be established by the New York State Hospital Review and Planning Council.

Administration

The New York State Hospital Review and Planning Council and the Office of Health Systems Management (OHSM) will continue to function in their established roles. The Council will be responsible for adopting reimbursement regulations subject to the approval of the Commissioner. OHSM will be responsible for the computation of hospital revenue caps based on the State enabling legislation and the regulations under NYPHRM. Once these revenue caps are established, OHSM will calculate Medical rates, Blue Cross will calculate Blue Cross rates, and federal fiscal intermediaries will figure Medicare rates. The Council on Health Care Financing, a legislatively created body, and the New York State Senate and Assembly Committees on Health will actively monitor remaining regulations necessary to implement NYPHRM.

Although not a panacea, NYPHRM offers significant improvements over previous systems. While some hospitals may find revenues reduced, most will receive greater income, and the industry as a whole will benefit financially. Facilities currently close to bankruptcy will most certainly be helped.

One of the conditions of federal approval of our new system was that hospital Medicare expenditures in New York State be kept 1.5 percent below the rate of national increase. We believe this to be an arbitrary cap which essentially provides a disincentive for states to cooperatively work with their hospital sectors to develop new and innovative uniform payment systems which will be beneficial to the federal government, as well as the public. In addition, such a requirement ignores past savings accrued by the federal government as a result of the cost containment initiatives taken in our State since 1969. While we shall attempt to meet that requirement, and indeed our rate of growth has been far below the national average for several years, the need to rebuild the infrastructure of our system after years of deterioration will make it difficult. We believe that similar limitation should not be imposed in the event that our system is extended beyond its December 31, 1985 expiration date.

NATIONAL PROSPECTIVE PAYMENT

The Secretary of Health and Human Services (HHS) has proposed that Medicare prospective payment be based on a diagnostic related group (DRG) method. While we will not be immediately affected by this proposal, we do wish to express the general concern that DRGs as a unit of payment is being proposed on a nationwide basis in the absence of adequate experimentation. We believe that states which currently have waivers to implement a non-DRG based system should be encouraged to continue their experimentation, and that other states, with the cooperation of their hospital sectors, be encouraged to pursue waivers to implement systems which may or may not be based on DRGs.

Should the Congress decide to pursue the HHS proposal, or any other prospective payment plan, we believe that the following principles should be included:

Rates of payment should be hospital specific, as is the case in New York, and not be based on a national average which would unduly penalize certain areas of the country and provide a financial windfall to others.

The argument that hospital specific rates would reward past inefficiencies is not valid for states—such as New York—which have had extensive experience with cost containment which has removed the fat from the system, and, in some cases jeopardized its viability. In other cases, appropriate adjustments can be made. At the very least regionally (i.e., SMSAs) based rates should be a part of the system.

Rates should be adjusted on a regularly scheduled basis to reflect inflation and new technology costs, as well as other factors, based on the most recently available cost reporting data. Such adjustments should be by a panel independent of HHS (such as the Independent Panel of Economists used under New York's system) which is capable of making an objective judgment.

While the NYPHRM system has, in general, resulted in a more equitable reimbursement system in New York, there is one major problem which may foreshadow a similar one at the national level. The conversion from a retrospective system for Medicare to a prospective one adversely affected a small number of hospitals. The Transition Fund previously described may not be adequate to correct the hurt incurred by the conversion, since the hospitals affected have a very high Medicare patient occupancy (overall New York is about 45 percent). The conversion from a retrospective Medicare system to a prospective one on the national level may produce a similar situation. Provisions must be made to preclude such intense hurt.

A strong appeals mechanism needs to be built into the system to provide hospitals the ability to seek adjustments when it can be demonstrated that a promulgated rate is inappropriate for its individual circumstance. The bases for appeals should include one related to hurt caused by conversion to the prospective Medicare system. In addition, the system should not preclude access to the federal courts to adjudicate disputes over the system and obtain relief.

We believe the system should provide for a "pass-through" of capital and teaching costs. These are issues which are of extreme importance to our State in particular.

The system should provide for an aggressive Medicare prospective payment waiver program under which a group of hospitals, or a state that has the support of the affected hospitals, can establish an alternative Medicare payment system. Waiver requests should be based on (a) a reasonable assurance that the applicant's proposal will result in total Medicare payments during the waiver period no greater that those anticipated under the federal Medicare prospective payment system; or (b) the proposal offers a significant opportunity to advance the state of knowledge concerning hospital prospective payment.

The system should be complemented by a health planning and peer review mechanism designed to assure quality control and appropriate utilization. Our Association supported enactment of the peer review provisions contained in the Tax Equity and Fiscal Responsibility Act of 1982. We are distressed to see that the President has proposed no funding for PSROs/PROs in fiscal year 1984 and urge that the Congress rectify the situation. Additionally, we support deemed status for those hospitals which can demonstrate an ability to conduct utilization review.

In the area of health planning, we strongly believe that federal financial support must be continued, but that states be given the flexibility for the development of their own system.

CONCLUSION

We believe that Congress should enact a prospective payment plan for Medicare this year which includes the principles outlined above. At the same time, it must be noted that we are a geographically expansive nation with diverse regions. The ability of states to experiment with other payment mechanisms must be maintained, and even encouraged. It is only through such experimentation that we can finally develop a fair and equitable payment system, which may differ from region to region, but which will ultimately be in the best interests of the public we all seek to serve.

STATEMENT OF INTERMOUNTAIN HEALTH CARE HOSPITALS, INC. PRESENTED BY DAVID H. JEPPSON, PRESIDENT

INTRODUCTION

This statement is submitted on behalf of IHC Hospitals, Inc., one of five health care related corporations of Intermountain Health Care, Inc., a not-for-profit parent corporation, with corporate offices in Salt Lake City, Utah. IHC Hospitals is a not-for-profit corporation which owns, leases, or manages 23 hospitals with a total of 2,898 beds and several outreach clinics in the Rocky Mountain area. IHC Hospitals, Inc. is a member of the American Hospital Association and the Associated Hospital Systems. We are pleased to offer this testimony on the proposed prospective payment system (PPS) for Medicare submitted by the Secretary of Health and Human Services.

BACKGROUND

IHC Hospitals, Inc. is concerned with the rising costs of health care. We strongly support the current reform movement in the Medicare system as a step toward curbing these rising health care costs. We endorse wholeheartedly the Medicare Health Insurance Certificate Proposal of the Associated Hospital Systems, which we understand has been submitted to this Subcommittee, as the most promising and effective reform. We would recommend continuation and intensification of efforts to develop this proposal as the future design of the Medicare payment system. However, we realize that such development may take some time and that both Congress and the Administration are seriously considering a DRG-based prospective payment system. Accordingly, our remarks will focus on suggestions which we believe would refine and improve the HHS Secretary's prospective payment proposal as an interim measure.

The basic intent of the PPS as proposed by the Secretary is to revise the incentives of the Medicare payment system. IHC Hospitals endorses this objective. Over the past several years, cost reimbursement has encouraged hospitals to spend money. On the other hand, a prospective payment system motivates hospitals to increase efficiency and minimize costs in order to avoid losses and to retain the difference between the prospective payment and the actual cost. This incentive offers a reward to efficiently operated hospitals.

We also support a prospective payment system based on diagnosis-related groups (DRG's). This system attempts to identify and set payment based on the acuity of individual cases, rather than an overall average for all cases as in TEFRA.

IHC Hospitals agrees with the Secretary that capital costs should be excluded initially from the prospective payments for DRGs. We stand ready to work with Congress and the Secretary to analyze the issues involved in including payments for capital costs in a prospective rate at some future date. We also agree that both direct and indirect costs associated with medical education programs in hospitals should be paid separately from the prospective payments for each DRG. We concur with the Associated Hospitals Systems' recommendation on this issue.

While we broadly support the overall concept of prospective payments as an interim measure, we would like to bring your attention to a number of specific changes which we believe would enhance the current HHS proposal. These concerns are discussed below.

Administrative discretion

We believe the final legislation implementing a prospective payment system should contain sufficient specificity so as to remove the possibility of administrative discretion in the initial establishment and subsequent adjustment of the DRG prices. The legislative specifications should apply to all aspects of the price setting methodology as well as to capital costs and teaching costs, both direct and indirect.

Over the past two decades, hospitals have experienced certain problems relating to the interpretation of legislative provisions which provide for administrative rulemaking and discretion. For example, hospitals and administrators have committed significant resources in attempts to resolve questions of allowable costs and other related issues. By removing administrative discretion from this area of the program, we can avoid such costly and unnecessary legal actions.

Scope of the PPS

We believe the prospective payment proposal should be limited in scope and applicability to the Medicare program. States should be permitted to continue to contract in a variety of ways for Medicaid beneficiaries. Private insurers, self-insured employers and individuals without insurance should not be covered under this prospective proposal. We believe that the free market should determine the prices that hospitals will charge non-medicare beneficiaries.

Benefits

We also believe that Congress should take this opportunity to specifically identify certain non-covered procedures. Technology continues to advance at a very rapid rate and many of the new medical innovations will lead to very costly procedures. We point to the implantations of artificial organs and organ transplants as examples. If Congress is to control federal expenditures for health care, we believe Congress has a responsibility to tell the American public the services for which payments will not be made.

Administration

At the present time, hospitals receive payments from fiscal intermediaries under the periodic interim payment (PIP) method. We believe that the PIP system should be continued under the prospective payment system. A simple settlement calculation at the end of the year could be performed to determine whether a hospital has been underpaid or overpaid. A proper settlement could then be made.

Hill Burton requirement for participation in medicare

The administration's proposal states that hospitals can either accept the DRG rates as payment in full or terminate participation in the Medicare program. However, hospitals with Hill Burton funds are required to offer services to Medicare patients as part of their on-going community service obligation. We recommend that this Hill Burton requirement be repealed to allow each hospital the actual opportunity to decide whether to participate in the prospective payment Medicare system.

Medicare bad debts

The administration's proposal is silent on bad debts resulting from Medicare patients' failure to pay the existing statutory deductibles and coinsurance amounts. We believe that bad debts arising from such failure or inability should be reimbursed as Medicare bad debts.

Physician incentives

The prospective payment contains a number of very strong incentives for hospitals to contain costs and eliminate unnecessary procedures. IHC Hospitals believes that the hospitals in our system are doing an excellent job in containing costs in minimizing excessive utilization of services as is demonstrated by our system-wide average length of stay of 5.2 days. While a prospective payment system would encourage us to try to be even more efficient, it does nothing to change the incentives associated with physician reimbursement.

The current method of paying a physician for doing more is inconsistent with the prospective payment incentive of encouraging hospitals to do less. Given the new economic incentives of a prospective payment system, hospital managers will undoubtedly find ways to place some limits on physicians' utilization of services. But, in our view, the real savings will not come about until the federal government changes the way it pays physicians for services.

Accordingly, we believe Congress should consider the practicality of paying physicians the same way it pays hospitals, i.e., a prospective price for a given case type. This would align hospital and physician incentives and would give the physicians the same opportunity to benefit by providing needed services efficiently.

We recognize that it may be impractical to change physician payment by October 1, 1983, but we encourage Congress to require the Secretary to report on such a system within the next year. In the long run, such as payment system for physicians will do far more to control program costs than HHS's present proposal of simply delaying increases in physician fees.

MEDPAR file: statistical variations

The MEDPAR file, a 20 percent sample of Medicare claims, forms the basis for determining the number of cases in, and the relative cost weighting index of, diagnosis related groups. It is our understanding that this file contains a significant number of errors—perhaps as high as a 40 percent error rate. The Secretary asserts that these errors are random and will be corrected by "a law of large numbers". If it is assumed that a "law of large numbers" is valid, such a law would be helpful only if: (1) the errors are actually random, and (2) it applies to hospitals with large volumes of discharges.

We are not convinced that the MEDPAR errors are random. A strong and convincing case can be made to support the allegation that the MEDPAR file contains systematic errors which tend to understate the relative intensity of the entire case mix file. This allegation is based on the fact that the MEDPAR file's clinical data was obtained from claim forms which were often prepared within two to five days of discharge, many days before the preparation of final discharge abstracts containing accurate clinical data.

In order to correct the potential technical errors contained in the MEDPAR files, we offer three recommendations. First, we suggest that an independent statistician, possibly from the GAO, review the Secretary's proposal to verify the statistical validity of the methodology.

Second, we suggest that an independent outside group be established to perform an evaluation of the accuracy of the DRG assignments appearing in the MEDPAR file. We believe this could be accomplished by selecting a random sample and examining either the specific medical records involved for those patients or their final diagnosis as entered into a national data base similar to that maintained by CPHA (Commission of Professional & Hospital Activities).

Finally, we recommend that the evaluative review of the MEDPAR file lead to specific recommendations, including specific time frames within which the data is to be corrected.

DRG weight assignment: not related to cost

The proposed methodology for DRG weight assignment does not yield an accurate reflection of the hospitals' costs of providing services for DRGs. The Secretary's method uses a simple average of daily routine costs, which includes such varied costs as those incurred in obstetrics, pediatrics, medical, surgical, short term psychiatric, rehabilitation, etc. Even though the costs for providing these services vary significantly, the Secretary's proposal recommends the use of an average of all these costs times the number of routine patient days to determine the average routine cost in each DRG. The same problem occurs in the special care area where costs of all special care unit costs are added together and then averaged.

Rather than being evaluated in individually, each ancillary department is placed into one of seven groups: operating room, laboratory, radiology, drugs, medical supplies, anesthesia, and other. The total departmental grouping ratio of cost to charges from the Medicare cost report is applied to the specific patient charges accumulated for each DRG. This methodology for determining costs in the ancillary areas would be correct only if hospitals had exactly the same markup for all services provided in each of those seven groupings.

The end result is something that the Secretary refers to as "cost" weights, when in reality the weights bear absolutely no relationship to the actual cost of services for each DRG.

To more accurately reflect costs, we recommend that: (1) an actual determination of costs be made; (2) another methodology be developed which approximates more accurately the actual costs incurred in each DRG; or (3) the notion of developing the weights based upon "cost" be abandoned and replaced with a national average hospital charge per DGR.

Determination and payment of the DGR price

The method employed to set the initial prices for DRGs is of utmost importance to the success of a prospective payment plan. The prices must be low enough to encourage provider efficiency and high enough to assure the long range viability of efficient hospitals and the ability for Medicare patients to receive services.

In the past the full costs of treating Medicare patients have not been paid by the government. Consequently, hospitals have been forced to shift Medicare costs to non-Medicare patients in the form of higher charges. This type of cost-shifting, which is basically a hidden tax on the American people, should be changed in the prospective payment system. We believe that the government has an ideal opportunity to reduce or eliminate cost-shifting without regulating private insurance (see section on Scope of PPS, supra).

To eliminate cost-shifting, we believe that the full cost of providing services plus a reasonable return must be included in determining the prospective payment rate for each DRG.

To compute a total average payment amount per case we would recommend the following:

(1) Determine the national average charge per case from the MEDPAR files.

(2) Adjust the average charge downward to eliminate depreciation, interest and medical education. This could be accomplished based on a percentage relationship of those costs to total costs as given on the Medicare cost reports.

(3) Determine the salary and non-salary component of the remaining amount (again by percentage relationships) from the Medicare Cost Reports.

(4) Adjust the salary component of the average charge by the Urban/Rural Wage Index.

(5) Add back the non-salary component of the average charge to determine the total locally adjusted average payment per case.

To determine the payment for each DRG we recommend using a method similar to the Secretary's with one exception: rather than using the average "cost weight" per DRG, use the average charge weight per DRG. This information could be obtained from the MEDPAR file. A specific formula to include anticipated inflation and technology changes should be set legislatively to update subsequent year payment rates (see section on Administrative Discretion, supra).

Realizing that the government is attempting to control their portion of Medicare payments, we agree that the prospective payment rate should be considered payment in full but recommended that the payment for each case be shared by the government and the beneficiary. The amount of payment for each could be set by determining the amount per average case the government is willing to pay and assigning the remainder to the patient.

The amount of patient liability for all DRGs could be expressed as a constant percentage or dollar amount. In this manner the beneficiary would know beforehand how much (or what percentage of the total) he would be liable to pay for each hospital stay. Under this scenario, the existing inpatient beneficiary deductibles and copayments would be replaced by the proposed DRG patient copayment described above.

We realize that not all Medicare patients will be able to pay the copayment and that some Medicare patients may be reluctant to seek needed treatment. To avoid these problems, a graduated percentage approach based on the amount of income of each Medicare recipient could be developed, lower income Medicare patients would be required to pay a smaller percentage of the DRG patient copayment than higher income Medicare patients. Any number of income brackets could be designated under this proposal.

Regardless of the method employed to determine prospective prices, we recommend that a comprehensive study of the methodology and its effects on hospitals and patients be legislatively mandated after the first two years of the program. This would allow potential inequities in the DRG prices to be corrected and DRG prices adjusted for future payment. In addition, further developments in vouchers could be reviewed, and both systems compared for future payment mechanisms.

SUMMARY

IHC Hospitals, Inc. supports the concept of prospective payments as a means of realigning provider incentives with Congressional and Administrative intent—to provide quality hospital services efficiently. In order to accomplish this purpose, the prospective payment plan proposed by the Secretary of Health and Human Services needs to be revised to ensure that Medicare payments to hospitals for services rendered will be just and equitable, that is, that they will be set at a figure which will encourage provider efficiency while assuring both long range viability of efficient hospitals and accessibility of services for Medicare patients. Adoption of the recommendations explained above will help in accomplishing these desirable ends.

STATEMENT OF ALVIN GOLDBERG, MOUNT SINAI MEDICAL CENTER OF GREATER MIAMI

My name is Alvin Goldberg, Executive Vice President of Mount Sinai Medical Center of Greater Miami. I am pleased to have this opportunity to testify to the House Ways and Means Subcommittee on Health on the Medicare prospective payment proposal submitted to Congress by Health and Human Services Secretary Richard S. Schweiker at the end of 1982. Mount Sinai Medical Center, a 699 bed non-profit voluntary teaching hospital, has the distinction of providing services to the largest community of elderly in the country, Miami Beach, where 52 percent are over 65. Over 72 percent of our patient days were provided to Medicare patients in 1982. Therefore, we are very concerned that any prospective payment system adequately and fairly compensate hospitals for services provided to the nation's elderly.

While it is difficult, to assess the exact effect of the prospective proposal on individual hospitals as the Health Care Financing Administration (HCFA) has not yet released all the details to determine the anticipated reimbursement by DRG, there are several aspects of the proposal that we question. First, in calculating the index HCFA used MEDPAR data base, a 20 percent sample of a hospital's Medicare admissions in 1981. Since this data base was designed only as a historical sample and not as a reflection of a hospital's case mix the quality of conclusions HCFA draws from the MEDPAR data is questionable. In addition, this data base does not account for the changes in medical practice between 1981 and 1984 (the year implemented).

Second, has the mix of services, as represented by the 1981 sample and the case mix index derived from the sample changed since 1981? HCFA has not made any allowances for such changes. In fact, HCFA considers any increases in Medicare admissions as being promoted only by incentives to take advantage of increased Medicare reimbursement offered by the regulations and will be accordingly adjusted downward. This attitude reflected in the prospective payment proposal (see pages 108-109 of the proposal) is also prevalent in the new Section 223 regulation recently promulated as per the Tax Equity and Fiscal responsibility Act of 1982 (TEFRA):

"Under the reimbursement system established by Public Law 97-248, a hospital may have an incentive to increase its number of Medicare patients. For example, a hospital that has costs less than the target amount will receive an increased payment per discharge above its actual costs. We are concerned that some hospitals may promote the increased admissions of Medicare patients to take advantage of this aspect of the reimbursement system. Such action would be contrary to the intent of the legislation, which was to reward efficient operation, not to stimulate increased hospital admission." (Federal Register), September 30, 1982. p. 43825).

There are no stipulations for the icrease in elderly population in a given service area or that population's aging and subsequent requirement for more inpatient hospital services.

Third, HCFA's data used to classify patients by DRG does not adequately account for multiplicity of diagnoses in patients, those patients who have more than one diagnosis during a hospital stay, and only accounts for, to a limited degree, complications that arise during his/her stay. In addition, the DRGs only address the age of the patients on a geater than or less than 70 basis. This could be a severe problem. Assigning one diagnosis related group to a patient on discharge, which dictates the reimburtsement an institution will receive, may not consider or be sensitive to the fact that different patients or varying ages with the same principle diagnosis may be considerably sicker and thus require more intensive utilization of resources. Low income elderly particularly fall in that category more often than others. There is currently a study being undertaken by the National Association of Public Hospitals to explore this fact in more detail.

HCFA believes that the DRGs account for the severity of illness or individual cases and the requirement for these cases for more intensive services. To quote from the Health and Human Services proposal:

"The degree of severity of illness is not uniformaly associated with treatment cost per case . . . Moreover, in DRGs where severity of illness is strongly associated with treatment cost, most hospitals will have patients that exhibit a range of severity levels. Thus, it is unlikely on balance that differences in the average level of severity across all DRGs for Medicare patients will cause any significant financial advantage or disadvantage to most general hospitals." ("Hospital Prospective Payment for Medicare," December 1982, p. 54.)

While this prospective payment proposal is more acceptable to hospitals than TEFRA's Section 223 provisions currently in effect, it is difficult to assess at this time the impact of reimbursement on hospitals. Whether the plan will compensate adequately for the increased costs associated with teaching programs (a lump sum for indirect costs of medical education is proposed by Health and Human Services while direct cost will be reimbursed as per the existing system), charity and bad debt, remains to be seen.

It is apparent that there still is widespread criticism of the plan and that hospital may have a difficult time. Adjustments for multiple diagnoses appears limited. A typical case, involving either longer or shorter lengths of stay (i.e. outside the statistically valid range of days for a hospital stay) in a particular DRG, otherwise known as outliers, should be justified for an additional payment. HCFA believes that the number of cases falling in this category will only be approximately 0.5 percent of all cases. In New Jersey this figure is approximately 30 percent. This is clearly a major concern of hospitals nation-wide and is inadequately addressed to date by the federal government. The consequences of inadequate reimbursement to hospitals in New Jersey for the outlier cases would be financially devasting.

The DRG prospection reibursement proposal's reduction in health care costs to the Medicare Program are real. However, the shifting of Medicare costs, not reimbrused by the federal government to other payors means private patients often covered by commercial insuors will be carrying an increased burden of costs. This has already been documented in the State of Florida by the Florida Hospital Cost Containment Board. It is estimated that in 1982 $64.79 per patient day extra costs are shifted to each non Medicare patient in Dade County because the Medicare program does not sufficiently reimburse hospitals for their services to these patients. This amount would rapidly increase over time as the government tightens the screws in a Medicare only DRG prospective reimbursement system. New Jersey covers all payors. This remains as one of the primary differences between the Health and Human Services proposal and New Jersey's DRG system.

In summary, if a DRG prospective reimbursement proposal adequately accounted for teaching costs, severity of illness of patients, charity care, and bad debt provisions and was implmented for all payors (Medicare, Medicaid and commerically insured patients) then the system could be most beneficial to: patients; who would receive quality care with costs equitably distributed among all payors; hospitals, who would receive adequate reimbursement for services rendered; the federal and state government; who would have simplier bureaucratic structures and a restrained rate of health care costs increases; and private insurors, who would no longer bear the brunt of cost shifting encouraged by the present Medicare program.

STATEMENT OF THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

DEAR MR. CHAIRMAN: The National Association of Private Psychiatric Hospitals [NAPPH] appreciates this opportunity to submit its comments with regard to the administration's medicare prospective payment proposal. This association has been actively involved in working with the Department of Health and Human Services to assure that the special needs of the psychiatric hospitals are recognized in any plan which is proposed.

NAPPH represents the Nation's freestanding (nongovernmental) psychiatric hospitals, comprising approximately 23,000 beds. These hospitals, with a variety of types of ownership, provide for the medical care and treatment of persons suffering from psychiatric disorders and impairments. The membership offers a wide range of comprehensive programs that are vital to address the needs of children, adolescents, adults, the elderly, the alcoholic, and the substance abuser. All of our member hospitals are accredited by the Joint Commission on Accreditation of Hospitals.

NAPPH has previously stated its support for imaginative and innovative proposals that would correct the present deficiencies in hospital reimbursement and provide for equitable payment methodologies. In considering the multiple elements common to the operations of psychiatric hospitals, any payment methodology must take into account items such as the development of patient treatment programs, adjunctive therapies, quality assessment programs, and costs associated with providing various treatment modalities.

Congress has long recognized the importance of these activities with respect to the unique programs of psychiatric hospitals and the differences between psychiatric hospitals and acute care general hospitals. Examples of such recognition exist within the Conditions of Participation for psychiatric hospitals in the medicare and medicaid programs where the Government has explicitly stated that therapeutic services, specific medical recordkeeping and staffing levels be required of psychiatric hospitals. The Conditions of Participation do not require nor mention these services for psychiatric units in general hospitals.

Furthermore, section 101 of the recently passed Tax Equity and Fiscal Responsibility Act of 1982 specifically requires the Secretary of the Department of Health and Human Services to consider the special needs of psychiatric hospitals in developing exemptions from and exceptions to the new cost limits which have been based on a case mix adjustment. We believe this committee, and Congress was correct in its judgment when it determined that a case mix index [CMI] was designed only for application in short-term acute care general hospitals.

As Congress begins its consideration of the administration's prospective payment plan, NAPPH feels compelled to point out the inapplicability of any diagnostic related grouping [DRG] based payment system to the specialty psychiatric hospital. NAPPH supports the Department's concurrence with our recommendation to exclude psychiatric hospitals from its proposal on the basis that "DRGs were developed for short-term general hospitals [and] their application to [psychiatric, long term care, and pediatric] hospitals would be inaccurate and unfair." The Department further recognized that the difference in lengths of stay between psychiatric hospitals and psychiatric units of short-term hospitals would essentially result in the exclusion of psychiatric hospitals. Furthermore, NAPPH would like to point out that psychiatric hospitals were not included in the data base used by the Department. The psychiatric DRGs were based solely on general hospital data. While these factors begin to speak to the limitations of applying DRGs to the specialty psychiatric hospital, it is imperative that Congress understand that it is the unique nature of the psychiatric hospital and its services which precludes its inclusion in a system that clasifies patients into groups that use length of stay as the primary measure of resource consumption.

The psychiatric diagnostic approach cannot be quantified to an extent that permits uniform classification by diagnostic related groupings. Of foremost importance in determing the treatment approach for a mentally ill patient is the degree of the severity of illness. The symptomatology manifested in each psychiatric diagnostic category varies with the unique characteristics of each individual patient to the extent that different plans of treatment (and, consequently, lengths of stay) are necessary. The DSM-III accounts for this variation in treatment by explicitly recognizing the multiplicity of factors with a multi-axial system of classification which accounts for primary diagnosis and secondary personality strengths and liabilities, accompanying physical disorders, relevant stress factors, and the level of functioning the individual achieved before the onset of illness. The DSM-III's ten major diagnostic categories, including 319 diagnoses, relate individual treatment needs to desired outcome reference to time limitations.

Length of stay is a particularly inappropriate basis for determining diagnostic groupings for psychiatric patients in specialty hospitals. Treatment of the physically ill generally can be related to a specific timeframe. Treatment planning for the psychiatric patient in a specialty hospital depends significantly on the intensity of the patients illness and a variety of other factors including: a patient's functional disability, environmental situation (such as socio-economic status), past history of illness, acceptance of treatment, and a supportive family and community network. DRGs do not take account of these unique circumstances. The payment system proposed does not account for all of the factors that dramatically affect the desired outcome and length of stay of treatment in a psychiatric hospital. The application of this system to psychiatric hospitals would violate two of the prerequisites that the original researchers at Yale University used to develop DRGs: (1) that the number of classes in the system be manageable, and (2) that the classes contain patients with similar expected measures of output utilization (such as length of stay). The application of DRGs to psychiatric hospitals is not conducive to either qualification.

The limitations in applying DRGs to the specialty psychiatric hospital have been recognized in the two states that currently implement a DRG-based reimbursement system—New Jersey and Maryland. Psychiatric hospitals in New Jersey are scheduled to enter the DRG program in January 1983. However, New Jersey officials are currently reevaluating the applicability of DRGs to psychiatric hospitals and are reviewing the appropriate means to exempt the specialty psychiatric hospitals from the program.

Maryland, which utilizes a variation of the DRG system, does not include psychiatric hospitals in its DRG program. Hal Cohen, Ph.D., Director of the Health Services Cost Review Commission, has stated that DRGs were "essentially not developed with psychiatric diagnoses in mind . . . [and] to think that psychiatric patients can fit into four or five categories is absurd." The Health Services Cost Review Commission is requesting legislative changes to exempt psychiatric hospitals from its jurisdiction.

While a DRG system is not applicable to psychiatric hospitals, NAPPH does support the concept of prospective payment. However, it should be noted that with respect to medicare, psychiatric hospitals represent an extremely small portion of hospital reimbursement, and therefore, are not a major cause of the increases in Medicare costs to the Federal Government. According to NIMH, in 1977, psychiatric hospitals represented a mere seven-tenths of 1 percent of the total amount reimbursed for all hospital care. This figure represented an increase of only one-tenth of 1 percent since 1969. In 1981, all psychiatric hospitals (both public and private) accounted for approximately $176 million out of the $40 billion medicare program.

NAPPH believes that it would be in the best interest of the medicare beneficiaries, psychiatric hospitals, and the Federal Government for Congress and the Department to work with the association to determine if, how, and when, psychiatric hospitals can be brought under the current DRG-based prospective payment proposal. NAPPH also believes that Congress should maintain the authority to determine the appropriate time such hospitals are included in the prospective payment plan.

We look forward to working with you and your committee to develop a prospective payment system applicable to psychiatric hospitals.

Statement of the National Committee for Quality Health Care

Introduction

Prospective payment reform has all the earmarks of an idea whose time has come. The disincentives to efficiency which are inherent in the prevailing system of retrospective cost reimbursement have plagued the nation's health care budget for years. In the spring of 1982, the American Hospital Association took a first step toward ending the dominance of retrospective cost reimbursement by proposing a system of prospective fixed-price payments to hospitals under Medicare. At about the same time, it became known that the Health Care Financing Administration (HCFA) had constituted a task force charged with developing the Administration's own prospective payment proposal. In August, the Congress added momentum to the prospective payment movement by requiring the Administration to propose a prospective payment plan to Congress by early 1983. In October 1982, HHS Secretary Richard Schweiker publicly announced the board outline of his Department's prospective payment proposal.

The National Committee for Quality Health Care has resolved to add its voice to the emerging debate on prospective payment reform. To this end, a special subcommittee of NCQHC members was formed during the summer of 1982 to address this question. Specifically, this subcommittee was charged to: (1) assess prospective payment as an alternative to the currently prevailing retrospective cost reimbursement system for hospitals; (2) review and critique the various proposals which are offered by groups and organizations; and (3) formulate a set of recommendations to help guide health policymakers on the question of prospective payment reform. This document responds to the subcommittee's charge in two ways. First, it contains a statement of general principles which should be observed in the design of any prospective payment system by the federal government. Second, it contains a set of more detailed guidelines for analyzing and evaluating specific payment proposals. While these principles and guidelines focus on prospective payment under Medicare, we intend that they be useful in evaluating more broadly based prospective payment proposals as well.

The NCQHC is a diverse group of corporations and organizations which share an interest in rational reform of the health care system in this country. Its members are for-profit and not-for-profit hospitals, HMOs and other health providers, along with corporations, firms, and organizations which supply goods and services to health providers. Its trustees are physicians, hospital administrators, health professionals, and corporate executives. Since its members and trustees represent virtually all sectors of the health care industry, the NCQHC is particularly well situated to address the question of reforming the method by which the bellwether hospital sector is paid for its services.

General Principles

The following general principles should be observed in the design of any prospective payment system for health care programs financed by the federal government.

1. While the federal government may encourage prospective payment throughout the health care industry, it should be a requirement of federal law only under Medicare.
2. The federal government should not promise more care than it is willing to adequately finance through the prospective payment system.
3. The prospective payment system should be actuarially and financially sound.
4. The prospective payment system should afford financial predictability both to the government and to providers.
5. The prospective payment should pay a fair price, i.e., that price which allows an effective and efficient provider to furnish quality services while meeting its full financial requirements. These requirements include a reasonable return on investment, regardless of whether the provider is for-profit or nonprofit.
6. The prospective payment system should be administratively simple, , and the payment rates should be objectively determined.
7. The prospective payment system should be equitable and should recognize that geographical differences and special circumstances impose differing requirements on providers.
8. The prospective payment system should have an appeal process.
9. The prospective payment system should maximize beneficiary cost-consciousness by involving the patient in the financial outcome of his treatment; patients' financial exposure must be limited by catastrophic coverage.
10. The prospective payment system should be seen as a step in the transition to locally determined, market-oriented payment mechanisms.

Guidelines for Analysis

The guidelines for analysis of prospective payment proposals fall into several categories. Each category is identified by a crucial aspect of any prospective payment system. The categories are as follows:

1. Benefits/Eligibility/Coverage: What benefits, patients, and payors are to be covered?

2. Determination of Payment: How is the payment, or "price," determined?

3. Cost-Sharing: What element of patient cost-sharing should be involved?

4. Reporting: What information must be reported by hospitals to payment agencies, and in what form?

5. Utilization Limitation: How will utilization levels be limited?

6. Administration: How should the prospective payment system be administered? Especially, how should the Medicare portion of such a system be administered by HCFA?

7. Special Problems: What provisions, if any, should be made for types of hospitals and types of costs which raise special problems (e.g., teaching hospitals, specialty hospitals, financially distressed hospitals, free care, bad debt, etc.)?

The guidelines which follow provide a framework of analysis for answering these questions. The questions themselves must be addressed, and answered satisfactorily, if prospective payment is to provide the financial controls and reform which are so badly needed by providers and payors alike.

Benefits/ Eligibility/ Coverage

1. The prospective payment system should be applied to the full range of inpatient and outpatient services currently reimbursed under Medicare.
2. Beneficiary cost-sharing provisions should be included; the current Medicare spell of illness requirement should be eliminated, and a co-payment requirement should apply to each admission.

Determination of Payment

1. Base year data used in implementing a prospective payment system should minimize the extent to which efficient providers are penalized and inefficient providers are rewarded.
2. A provider's performance under prospective rates during one time period should not affect the rates which are applied to this provider for subsequent periods.
3. Currently available data should be used in order to permit a phased-in implementation within a relatively short period of time, and without resort to complex formulas.
4. The payment system in both current and future years should permit the predictability of government expenditures and hospital revenues.
5. The development of base-year information should recognize the special circumstances of individual providers, differences in economic requirements because of regional variations, and the special requirements associated with medical education, research, maintenance of capital, charity care, bad debt, and malpractice insurance.
6. There should be an exception/exemption/appeal process for new hospitals, small hospitals, and hospitals with extraordinary costs beyond their control, and for other appropriate circumstances.
7. Cumbersome reviews and analyses of individual provider costs and revenues should be held to a minimum.
8. Determination of payments should balance risks and rewards in order to encourage efficient and effective hospital management.
9. Prospective payment rates should be updated at least annually, with provisions for interim adjustments to accommodate extraordinary cost changes which are beyond the hospital's control.
10. Caution should be exercised in using formulistic economic indices to update rates. Independent authorities should be consulted.

Cost-Sharing

1. Patient cost-sharing is essential in order to assure that the prospective payment system is actuarially and financially sound.
2. The patient's cost-sharing obligation should be linked to the patient's ability to pay.
3. For all patients, regardless of income, there should be a stop-loss or maximum payment figure, beyond which their cost-sharing obligation ceases.
4. The cost-sharing obligation should include a coinsurance feature.
5. The patient should be required to indemnify the provider for costs not covered by the system, up to the patient's stop-loss or maximum amount.

Reporting

1. The reporting documents should be stripped of all information requirements other than those which are reasonably necessary to determine program payment to the provider.
2. The reporting document should be simple and easy to understand.
3. Information which is desired by HCFA for reasons other than immediate administration of the payment system, e.g., as a data base for policy reform, should be acquired through surveys which are independent of the cost report form.
4. The current Medicare cost report form should be abolished.

Limits on Utilization

1. It is essential that there be independent monitoring or control to assure appropriate levels of utilization and to maintain high quality of care.
2. Physician involvement is essential to utilization control. The methodology for paying physicians should contain a financial disincentive to unnecessary utilization, and should be consistent with the hospital payment methodology.
3. Both inpatient and outpatient services should be covered by the prospective payment system, to the maximum extent possible, in order to avoid unwarranted shifting of costs and services from the inpatient setting to the outpatient setting.
4. Patient cost-sharing is essential to assure the actuarial and financial soundness of the system and as a buffer against unnecessary utilization.

Administration

1. Administration of the system should be delegated by HCFA to private sector payment agencies to the maximum extent possible.

2. HCFA's role should be limited to setting broad policy and monitoring and auditing performance of the payment agencies.

3. Provider appeals should be heard by a tribunal which is independent of HCFA.

4. HCFA should establish program-wide policies, and should determine any quantitative factors which are necessary for program-wide administration of the payment system, in consultation with independent experts.

5. The private payment agencies should set hospital-specific payment rates consistent with broad policy and program-wide quantitative factors determined by HCFA.

6. The payment agencies should be chosen through flexible means, including competitive bidding, with due weight being given to experience and ability.

7. The payment agencies shall be compensated on the basis of prospectively determined amounts.

8. Quantitative norms for the performance of payment agencies should be developed, and these agencies should be held accountable for attaining these norms.

Special Problems

1. The medical education and research functions should be segregated from patient care, and paid for separately.

2. The prospective payment system should give institutional providers a reasonable opportunity to preserve necessary capital.

3. The prospective payment system should include an equitable mechanism for paying such shared costs as free care, bad debts, and malpractice insurance.

4. There must be special provisions for financially distressed hospitals which uniquely fill a community need.

5. Special provisions must be made, if warranted, for small hospitals, rural hospitals, and specialty hospitals.

6. There should be special incentives for continued development of innovative delivery systems, e.g., HMOs, which have proven to be cost-effective.

STATEMENT OF THE NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES

The National Federation of Licensed Practical Nurses is pleased to have the opportunity to present its views on President Reagan's prospective payment proposal for medicare.

As the professional association representing the nations 750,000 licensed practical nurses, we are particularly concerned about the cost of health care, as well as the quality. Our concerns are that those who are in need of medicare services should have the opportunity to receive quality care at a reasonable cost. We are also concerned that the efforts to reform the medicare program should not be done with the idea that this is an alternative to a national health care system.

As nurses and patients, we are deeply concerned abut the high costs of health care and that the costs of health care continue to rise at a more rapid rate than any other component in our economy.

In our testimony today, we would like to address the prospective payment proposal mechanism for Medicare based on the Diagnostic Related Group [DRG's]. Under this system, Medicare would establish the rates in advance rather than by costs hospitals incur in treating patients. The Department of Health and Human Services would establish these rates based on a patient's diagnosis using one of the 467 DRG's to classify the patients illness or treatment. All hospitals will be paid at the same rate but there would be an adjustment for local labor costs.

We agree with the concept that health care costs must be contained and that while last years Tax Equity fiscal Responsibility Act made an effort to contain costs by adding incentives to the program, there is no overall system which urges the delivery of health care to be cost efficient.

We support the concept that there must be incentives to keep health care costs down, but the suggested changes by the administration do not in our opinion, provide a system which protects the elderly and disabled.

We believe that this system might increase the burden on those who can least afford it and we are concerned that under the administrations proposal, the concept of prospective payment applies only to medicare. The Federation believes that the cost containment applies to all payors. If there is no conformity among all participants the system will lead to different quality levels of care. It will, in fact, create a system of private health care, public health care and Medicare.

Secondly, the prospective payment concept should apply to all providers. The idea that just hospitals are the only providers of health care is unrealistic. In general, we are concerned with the following problems:

(1) We want to avoid a system which will place an unfair burden on the public and non-profit hospitals in treating those patients who are most ill and therefore are the most costly patients.

(2) We want to have a professional standard review system which includes all providers, hospitals doctors, registered nurses and licensed pratical nurses. Quality assurance and peer review is an essential of any program which attempts to insure a quality care.

(3) We have concerns that the DRG mechanism may not be the most appropriate. It is difficult to have a mechanism, such as DRG, to fully compensate for the needs of a particular patient or family. There might be circumstances where additional support from nursing personnel is essential and that the general category described by the DRG may not allow for this exception. We are concerned, too, that the DRG may not provide highest quality care.

(4) The processes described by the administration shows a basis of favorable treatment for surgical procedures as opposed to nonsurgical procedures. It is conceivable and entirely possible that surgical procedures will not be curtailed and, in fact, may be encouraged.

Our major concern is to be able to give the public total and complete quality health and medical care, including nursing services. In this regard, we believe nursing services are an integral part to health care delivery and that total care, in fact, in many times is the primary reasons for hospital care in the first place. The failure of our present system to identify nursing services is unwise. Classified under routine operating costs, nursing services run the risk of being the first area cut during cost efficiency efforts.

We believe that the present system does little to curtail rising costs of health care. However, we see many deficiencies in the administrations proposal for prospective payments. We believe that an overhaul of the system is necessary to place cost incentives in the program but before we institute new policies and procedures to achieve this goal we must be sure that it is fair and reasonable to the patients and to the health providers.

We thank you for the opportunity to share our views on this matter and we hope that you will again seek our views in regard to this important health care matter.

Statement of Louis P. Scibetta, President, New Jersey Hospital Association

Mr. Chairman and members of the committee, I am Louis P. Scibetta, President of the New Jersey Hospital Association. The association, which represents all the hospitals in New Jersey, wishes to express its appreciation for the opportunity to appear today and present testimony on the Department of Health and Human Services plan for medicare prospective payment to hospitals.

As you know, New Jersey hospitals are entering the fourth year of a 4-year "waiver" granted by the Federal Government where medicare and medicaid have waived their principles of reimbursement and have agreed to pay hospitals pursuant to a state-approved prospective DRG rate schedule As a consequence, no other state in the nation has had the experience that New Jersey has had with DRG hospital reimbursement.

It is my intent today, Mr. Chairman, to pass along to you and the other members of the committee our views of the proposal based on the experience our hospitals have had with such a system.

The prospective plan submitted by the Department of Health and Human Services proposes to pay DRG payment rates for inpatient hospital care received by medicare patients. The Department has indicated that it can implement the plan on October 1, 1983.

The following remarks address methodological and procedural aspects of the proposed plan. The methodological comments focus on how prospective prices are to be calculated. The procedural remarks relate to details that must be considered in designing a prospective plan.

I would like to preface my remarks by emphasizing that in reviewing the New Jersey experience, it is crucially important to distinguish between Diagnosis Related Groups [DRG's] and chapter 83 of the laws of 1978, our State law on hospital reimbursement. DRG's are a patient classification scheme. Chapter 83 set the ground rules for hospital rate calculation. In New Jersey, chapter 83 gurantees the solvency of effectively and efficiently operated hospitals.

PROSPECTIVITY

The payment rates are to be established prospectively, based on historical costs, and are to remain unchanged during the rate year. Hospitals are to be allowed to retain or absorb the entire difference between the payment rates and actual cost.

We applaud the notion of prospectivity and welcome the intention to build reasonable incentives into the proposed program. Prospective rates augment the ability of hospitals to plan and budget, primarily because revenues for the upcoming year can be projected more accurately than otherwise. Meaningful opportunities to earn discernible incentives will motivate hospitals to function as efficiently as possible. Rarely are incentives found in fully cost-based reimbursement schemes.

Our experience with prospectivity in New Jersey has taught us, however, that prospective systems are significantly cleaner in theory than in practice. One major difficulty is the timeliness with which the rates are issued. Last year, for example, 20 to 25 New Jersey hospitals had not received their 1982 prospective rates by late September. Yet those hospitals' income for the year was pegged to those rates. Another problem relates to the fixed nature of the rate. The Medicare proposal wants the rate to remain unchanged during the year, a goal that is extremely problematic in practice. For example, an absolutely fixed rate precludes adjustment for serious misprojections made in arriving at future rates and corrections of subsequently uncovered errors. To keep rates fixed under these circumstances is simply inequitable.

In this vein, we are extremely concerned with the Department's proposal to implement a plan that is not subject to judicial review. "Payment amounts, exceptions, adjustments, and rules to implement the prospective payment system would not be subject to any form of judicial review. Retroactive adjustment of the payment rates, as might result from judicial review, is unusual to the basic purpose of prospective system." (p. 41)

Hospitals should not be denied judicial review if they wish to contest aspects of their approved rates. If the plan is as sound as claimed and is implemented fairly with sufficient lead time, few hospitals will need to resort to judicial review, which should minimize the Department's concerns about judicial review possibly leading to "chaotic results."

DIAGNOSIS RELATED GROUPS

The latest or ICD-9-CM Diagnosis Related Groups [DRG's] will be used to define a hospital's case-mix and to establish a hospital's payment rates for Medicare beneficiaries. The plan proposes to use 356 of the 467 DRGs and to modify them to accommodate Medicare data.

The DRGs have proven to be an indicator of the types of inpatients treated and are useful for various purposes. Users must realize, however, that the groups are not as medically meaningful nor as "homogeneous" as they might ostensibly appear to be. Our experiences in New Jersey and our analyses of medical records and patients' bills have clearly demonstrated that most groups contain numerous patients with disparate medical needs. The heterogeneous nature of the groups is due partly to the fact that all diseases and illnesses were collapsed into 467 groups so the system would be manageable. The severity of a patient's illness is considered only to a limited extent, and no more than one complication or comorbid condition is used to assign patients to the DRGs.

The heterogeneous nature of the DRGs means that the groups are only approximations of a hospital's case mix. This nature may explain why DRG-based studies failed to find that public hospitals with a disproportionately large number of low income of Medicare patients treat patients who are sicker than average. In any event, the heterogeneous nature of the DRG's can easily cause many problems when hospitals are reimbursed on the basis of group averages.

REIMBURSABLE COSTS

The DRG payment rates are to include all historical inpatient costs exclusive of capital-related and medical education costs. These excluded costs will essentially be treated initially as pass throughs and Medicare will pay its full share of incurred costs.

Unlike the system now operational in New Jersey, the proposed plan does not specifically address how new costs incurred after the base year (presumably 1981) but before the rate year (1984) will be handled. The plan implies that a generic inflation adjustment will be used for this purpose. Yet the adjustment is apt to be wholly inadequate for many hospitals that added new beds and services, and did so under the aegis of an approved certificate of need. Also, as is the case in New Jersey, an amount must be included in the adjustment that recognizes how inflation limits a hospital's ability to replace capital assets. Hospitals must have a forum to seek reimbursement for these costs.

We are also concerned about the plan's silence concerning imbursing hospitals for the implementation and ongoing costs that will definitely be required to report the necessary information and to manage under the new plan. DRG-based reimbursement will increase the cost of operating the medical record, billing, data processing, and other departments. Additional staff and equipment will be needed to collect, code, and process clinical and financial information. Hospitals must have access to computer technology to assign patients to the DRGs. The plan should ensure that hospitals will be paid for new regulatory costs just as was done in New Jersey when DRG-based reimbursement was launched. The plan should also indicate the types of information that hospitals must collect in order to cover their implementation costs.

Grave concern must also be expressed about the Department's refusal to reimburse uncompensated care, which consists of bad debts and the unpaid costs of caring for medically indigent people. Medicare has historically refused to pay for the uncompensated care associated with treating nonmedicare patients. Under New Jersey's tight plan, this cost is spread proportionately among all payers. The prospective plan should be modified to require medicare to pay a share of these costs. Medicare's continued refusal to do so may jeopardize the ability of many hospitals, especially those in the inner city, to continue providing quality care, especially in light of medicare cutbacks mandated by the Tax Equity and Fiscal Responsibility Act of 1982.

PAYMENT RATES

The proposed plan would establish about 300 sets of DRG rates, one for each SMSA and non-SMSA area of the Nation. The rates for any area would reflect the average cost of treating patients in given DRGs. These rates will apply to all hospitals in each area unless they receive an exemption or an adjustment. Specifically excluded from the plan are psychiatric, long term care and pediatric hospitals. The rates would represent full payment for Medicare impatient services, with beneficiary cost-sharing restricted to legally-mandated co-payments. The rates will be paid for all Medicare patients except outliers—patients with atypical lengths of stay. Reimbursement for these patients may equal the DRG rates plus a percentage of charges for each day beyond the high outlier point.

Reimbursing all hospitals in an area at an average adjusted cost per DRG might be defensible if patients clustered around the average. The average would, in this case, be representative of the typical patient. Data for New Jersey clearly show that in most DRGs, the average is unrepresentative of many, many patients. Hospitals may therefore suffer substantial losses for reasons outside their controls. Among the hospitals most likely to lose money are those that treat a disproportionate number of older, elderly patients and patients within a DRG who have more complicated, servere illnesses.

One reason why medicare averages will be unrepresentative of typical patients will be the wide trim points used to identify outliers. Medicare proposes to use a method that will yield trim or cutoff points substantially wider than those used in New Jersey. To illustrate, the low and high trim points for DRG 1 are 6 and 36 days in New Jersey, but would have been roughly 6 to 84 days is the Medicare method has been used. As a result, the patients within the Medicare DRGs are likely to have much more heterogeneous medical needs than is the case in New Jersey. This problem can be minimized by narrowing the trim points.

New Jersey has minimized problems related to the unrepresentativeness of the DRGs by narrowing the trim (cutoff) points used to define outliers, or patients with atypical lengths of stay. In addition, five other classes of patients are treated as outliers, including patients in DRGs will fewer than 6 patients, patients in DRGs with poorly defined clinical characteristics, patients who discharge themselves against medical advice, and others. Approximately 30 percent of the patients in New Jersey hospitals were outliers in 1979. These patients accounted for about 25 percent of total hospital operating costs (Exhibits 1 and 2).

The plan speaks about average payment rates but does not indicate whether the average will be a mean or median. The difference is important because the median is about 7 percent below the mean. Use of the median would cause increased financial problems for hospitals and reduce the extent to which incentives are built into the program. Use of median averages would impose harsher penalties on hospitals with sicker than average patients.

The plan does not explain how 1981 rates will be rolled to 1984. It indicates that an inflation adjustment might be made that includes a 1 percent add-on designed to cover increases in the cost-per-medicare discharge due to factors other than inflation. Among the possible noninflationary reasons why this cost could rise are new medical technology, increased intensity of care, new services, legally mandated changes, and the rising age of the elderly population. In the case of the first three possibilities, additional costs may be incurred under an approved certificate of need.

We are not aware of any study that demonstrates the adequacy or desirability of the one percent allowance. Indeed, recent studies conclude that the intensity of care alone rose roughly 3 to 4 percent per year for the decade ending in 1979. Therefore, the 1 percent is inadequate and will not meet the typical hospital's full financial requirements.

Even if the trim points are narrowed, many hospitals will incur financial hardship when all hospitals in an area are paid the same rates. In many cases, these rates will bear little relationship to a hospital's own cost for reasons outside its control. Given the heterogeneous nature of the DRGs coupled with the "radical" nature of per case reimbursement, the initial rates should be based on a hospital's own cost at the time it enters the new program. This will avoid the inherent problem of paying everyone at group averages while the fixed cap on spending forces hospitals to suppress spending.

New Jersey also minimizes problems related to the unrepresentativeness of the average rates by placing heavy reliance on a hospital's own cost in calculating the payment rates. Hospitals are therefore protected against problems related to the DRG grouping method. Furthermore, predicating payment rates on individual costs is no more expensive than paying everyone at the same average rate.

Basing the rates on actual costs will also respond to other problems with the rate calculations. For example, the Department's proposal does not make allowances for differences in hospital size, although cost usually varies directly with size because of enlarged service capacity. In addition, the grouping process ignores the fact that some hospitals may treat certain patients (e.g., psychiatric patients) in special units. The process also ignores the fact that hospitals with exactly the same medicare DRG mix may have considerably different non-Medicare DRG patient mixes, which can have a marked effect on costs.

Unlike TEFRA, no automatic exception is granted to small rural hospitals. Because of the new reporting requirements and needed access to computer services, these hospitals should be allowed additional lead time to adjust to the new plan, if not exempted entirely. Payment of average rates may also be especially harmful to small hospitals. The reason lies partly in the fact that most DRGs often contain only a handful of patients. In New Jersey, where all patients are reimbursed DRG rates, and most hospitals have over 250 beds, approximately 100 of the 393 DRGs with acceptably defined clinical characteristics had around 500 patients statewide, or about 6 patients per hospital. About 70 percent had no more than 3,000 patients, or 30 patients per hospital.

Another area of concern relates to the constraint that the plan proposes to place on DRG prices. Page 45 of the proposal states: "the actual level of prices initially will be determined by the constraint that the prospective payment system not increase Medicare outlays over the amount that would be spent were the present TEFRA system of limits continued." The Tax Equity and Fiscal Responsibility Act tightened Medicare reimbursement significantly. To ratchet down from this reduced level at the same time that an entirely new payment plan is inaugurated introduces too many shocks into hospitals over a short time. This is also a dangerous approach because DRGs have not been tested on a national scale. Experiences with essentially 100 New Jersey hospitals suggest that many problems will arise during the startup year.

ERROR RATES

The proposed plan and an article in a recent HCFA journal (Health Care Financing Review, December 1982) report that the sample of bills in the MEDPAR file are replete with errors. Perhaps 20 to 30 percent of the bills in the MEDPAR file contain errors that may affect DRG assignment.

The Department makes the assumption that errors will to a large extent be self cancelling. In any event, adverse consequences of data errors can be minimized if the rates are initially based on a hospital's actual costs and payment is based on case mix in the rate year rather than case mix in the base year. Use of historical case mix will not allow for case-mix changes occurring between the base and rate years.

Furthermore, the Department's observation that "there is no evidence from New Jersey" that false coding of patients' medical records is a problem needs to be emphasized. Hospitals have been criticized unjustly for taking meticulous steps to code properly. Under per diem reimbursement systems the diagnosis codes did not determine reimbursement. As soon as they do—as can be expected—every legitimate effort will be taken to scrutinize this area of a hospital's operation. The fact should be emphasized that there is no indication in New Jersey of the phenomenon labelled "DRG creep" or coding up to enhance reimbursement.

IMPLEMENTATION TIME

The Department of Health and Human Services has indicated that it could begin implementing its plan on October 1, 1983. Hospitals would be brought into the program based on their cost reporting period.

Because of problems inherent in a uniform startup date, we agree that hospitals should be phased into the program based on their cost reporting periods. However, it is absolutely essential for hospitals to have sufficient lead time, at least 6 months, to learn about the program, adopt the requisite changes necessary to meet the regulations, and to educate staff about what is expected from them under this entirely new system of reimbursement. Widespread confusion will result if the plan is implemented too rapidly. The consequences are apt to spill into the future insofar as hospitals are unable to collect information needed for reimbursement.

REPORTING REQUIREMENTS

One of the Department's objectives is to reduce Medicare reporting requirements. New Jersey experiences suggest that the paperwork hospitals face will increase considerably under DRG-based reimbursement. In short, any reduction in Medicare reporting requirements may easily be overpowered by information hospitals must collect and have to operate under the program.

DETAILS OF THE PLAN

There is merit in many of the components in the proposed plan. We are concerned, however, that important details of the Department's proposal are missing.

This limits the ability of hospitals to comment on the proposal and to gauge its financial impact. The following are indicative of some of the missing details:

This plan does not describe the adjustment methodology that will be used to pay teaching hospitals the same DRG rates as other hospitals.

The plan does not indicate whether mean or median costs per Medicare discharge will be used to establish DRG prices. As I stated earlier, median rates would be about 7 percent lower than mean rates.

The plan does not explain how the rates will be adjusted for technologic developments occurring between the base and rate years.

The plan does not indicate how or how often the DRG prices will be calculated after the first year.

The plan does not explain how base year costs will be rolled forward to establish future rates.

The plan does not explain how outliers will be identified and reimbursed, an omission that is especially important for small hospitals.

The plan does not explain how hospitals will be paid for patients who were admitted in one year and discharged the following year.

The plan does not indicate what type of exceptions and adjustments would be granted to sole community providers.

The plan does not indicate whether an annual technology allowance will be added to the rates.

Apart from missing details, in at least two places the plan seems contradictory. These problems may have important financial implications. First, page IV states that "all patients can be categorized into one of 467 different groups," while page 43 indicates that "the category definitions cover virtually the entire patient population." The latter statement is correct. As presently constructed, patients with an operating room procedure unrelated to the principal diagnosis are assigned to DRG 468, one of three catchall DRGs. About 5 percent of the MEDPAR file falls into DRG 468. The proposal must address how these patients will be reimbursed.

Second, rate calculation schemata on page 81 indicate that 1981 costs adjusted for inflation and other factors will be used to set 1984 rates. Yet, according to page 45 medicare payments will be limited to "the amount that would be spent were the present TEFRA system of limits continued." These two approaches may yield significantly different payments.

In conclusion, Mr. Chairman, I hope these comments will prove useful to this committee as it considers this proposal and others such as the American Hospital Association's prospective plan. We commend these efforts and these hearings as an attempt to develop an equitable, effective reimbursement system. We are proud of our accomplishments in New Jersey in serving as a "laboratory" for the nation in testing new systems. We reiterate our sincere offer to share what we have learned and stand ready in this capacity to assist this committee in any way we can.

I would be pleased to answer any questions you may have

Exhibit 1

PERCENT DISTRIBUTION OF INPATIENTS

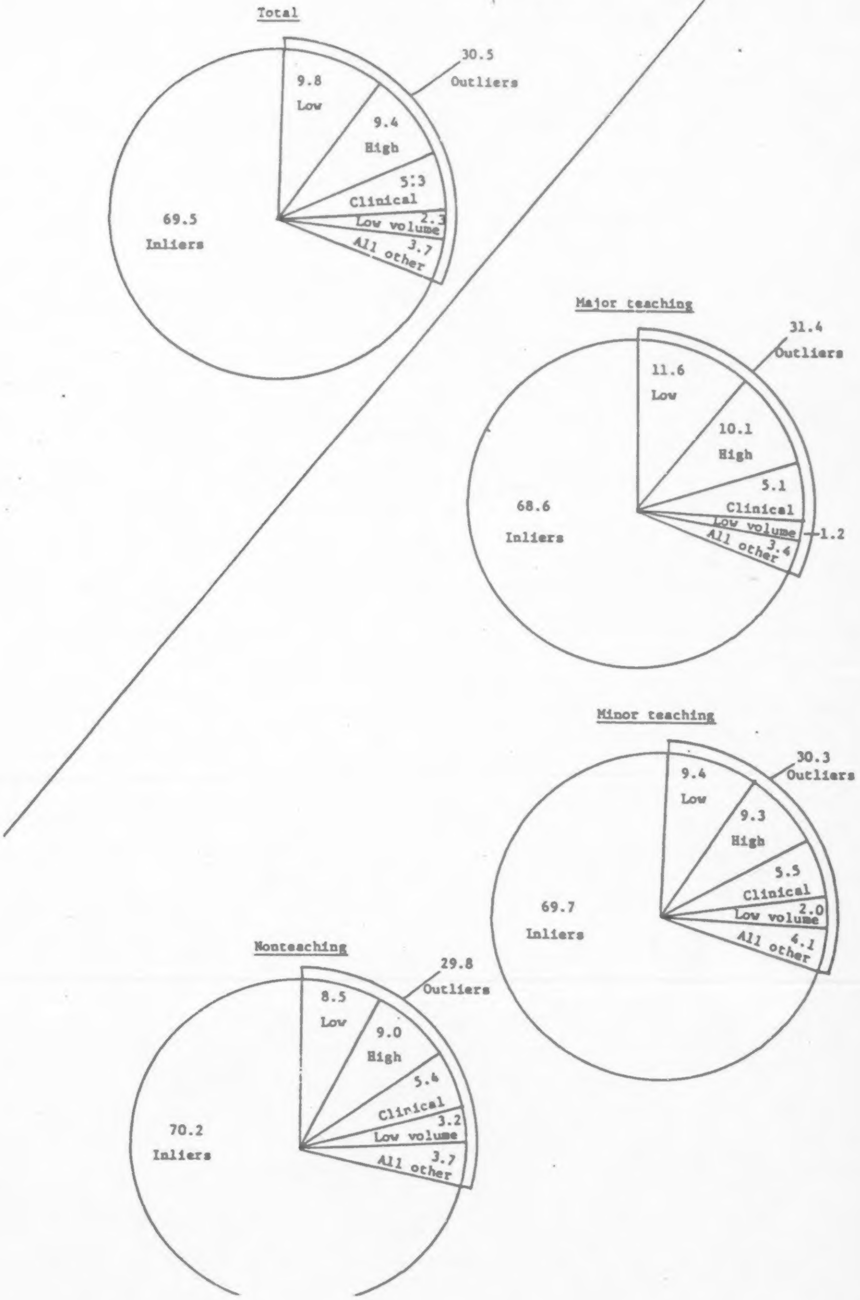
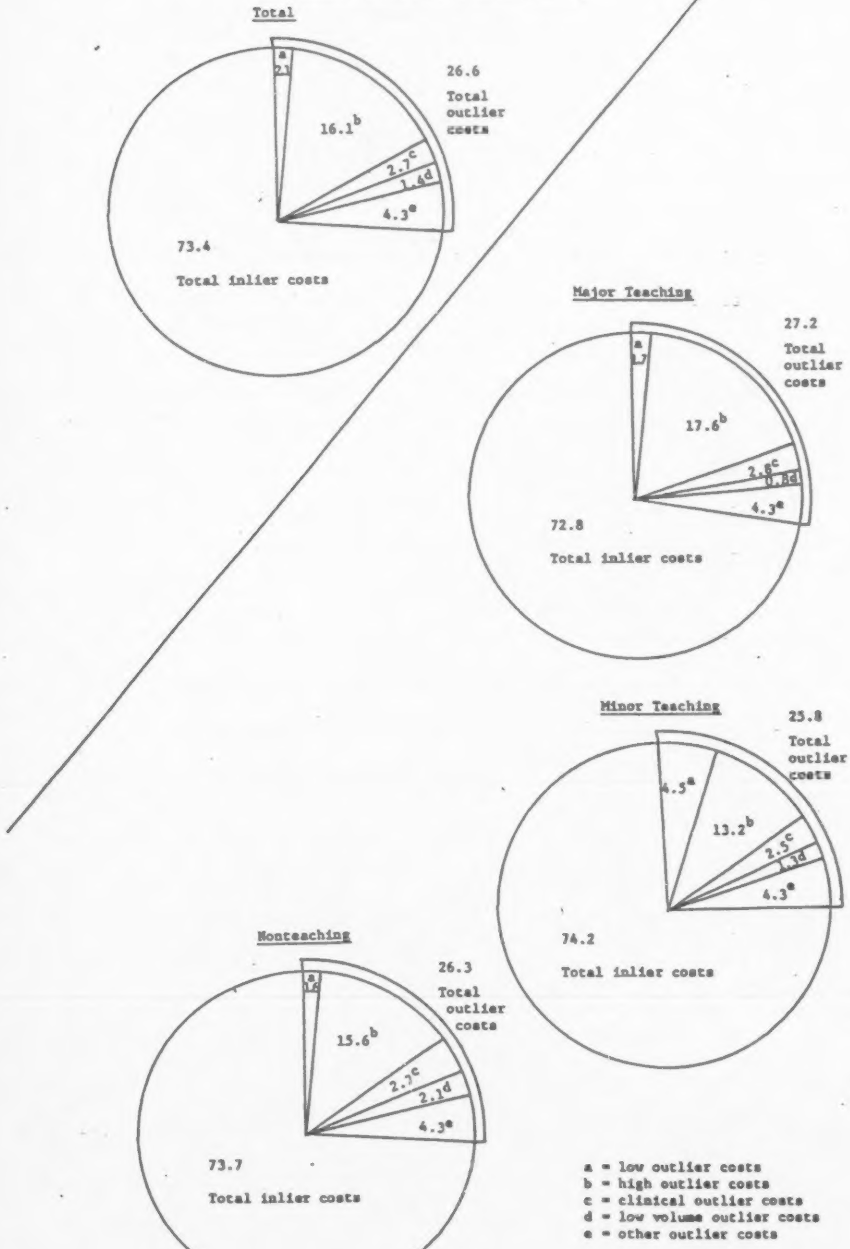


Exhibit 2

OUTLIER COSTS AS A PERCENT OF TOTAL COSTS
(includes incentives & disincentives)



Total

Major Teaching

Minor Teaching

Nonteaching

a = low outlier costs
b = high outlier costs
c = clinical outlier costs
d = low volume outlier costs
e = other outlier costs

STATEMENT OF STANLEY BREZENOFF, PRESIDENT OF THE NEW YORK CITY HEALTH AND HOSPITALS CORP.

We are pleased to have this opportunity to comment on the Administration's proposed system for prospective payment of hospitals under Medicare. As public providers, we view this as a particularly critical time in the evoluation of our national system of health care financing. The implementation of a well-developed prospective system of payment under Medicare would be a significant step forward in the effort to restrain health care costs while maintaining access to health care services.

In my statement for the record, I will describe how the Administration's proposed payment system as currently drafted would affect the New York City Health and Hospitals Corporation, the largest municipal hospital system in the country. I will also outline several measures which we believe must be included to insure the viability of our hospitals and our ability to provide for our patients, should a national prospective payment system be enacted. They are measures which, to varying degrees, underly the New York State system of payment which began evolving toward its current form in 1969. As you know, the State is currently operating under a three-year waiver from the Health Care Financing Administration which permits it to operate a prospective system of reimbursement under Medicare. In addition, the State reimburses prospectively under Medicaid and Blue Cross, thus including all major payors in our system.

Let me begin by briefly outlining for the record the exact nature of the Corporation that I represent as President. As I noted above, we operate the largest municipal hospital system in the country. It is comprised of 12 acute and four long-term care facilities, 36 community clinics and neighborhood family care centers and the emergency medical services system for the City of New York. We operate on a budget of $1.6 billion. Nearly one third of a billion dollars ($329 million) is funded by the New York City tax levy, $283 million by Medicare, and $702 million by Medicaid which in addition requires a 25 percent contribution by the City.

We provided over 3.2 million inpatient days of care in our facilities last year, and 4.1 million outpatient visits. HHC provides care to all patients regardless of their ability to pay; the overwhelming majority come from poor and low income areas of the city. The poor socio-economic status of our patients has a profound impact on their health status, which in turn influences the services we are required to provide.

EFFECT OF THE PROPOSED PAYMENT SYSTEM

It is this latter issue—the special needs of poor and low income patients for care—which is of particular concern to us, as we evaluate the potential effect of the Administration's proposal on our Corporation.

Specifically, we are concerned with the method of classifying patients into diagnostic related groups (DRGs) as a basis for determining rates of reimbursement. Research undertaken at John Hopkins University and elsewhere on this issue indicates that DRGs do not, contrary to the intent of that approach, produce homogeneous groupings of patients with respect to severity of illness. As a result, under a DRG-based reimbursement system, inner city hospitals serving more seriously ill patients within individual DRGs would be inadequately reimbursed for the care they provide.

Recently, our Corporation commissioned two separate studies* to determine how the population we serve influences the amount and type of services we deliver. The first study was specifically conducted to determine the potential impact of a DRG system on our hospitals vis-a-vis private facilities. The second study evaluated the medical needs of patients who were found by our State Department of Social Services to have excessive lengths of stay.

We are submitting copies of our studies for your staff to review. In addition we are providing a summary of these documents and related correspondence to HCFA which we hope may be included with our statement as part of the record.

The findings of both studies are extremely persuasive in documenting:

First, that in general, a greater intensity of service is in fact required by a disproportionate number of our patients, in comparison with patients served by private facilities; and

Second, that the DRG system is seriously deficient in taking into account the factors which are measures of the higher levels of care provided. In particular, it was found that our patients have a greater severity of illness and longer lengths of stay, which in turn are factors associated with higher costs.

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*"The Impact of Case Mix Measures on HHC Hospitals," by Jeffrey Merrill and Michael Schwartz; and Bellevue Hospital Center—1982 Length of Stay Appeal.

Last year, this Committee sought to address this concern through the enactment of Sec. 101 of the Tax Equity and Fiscal Responsibility Act of 1982. Under this provision, hospitals serving high proportions of Medicare and low-income patients were allowed an adjustment to their Sec. 223 cost limits, subject to the discretion of the Secretary of the Department of Health and Human Services. Unfortunately, no regulations have been promulgated implementing this provision of the law. We would hope that through our testimony we can illustrate the need for similar consideration under any national system of prospective reimbursement that is developed. However, we would also hope that the Secretary of the Department of Health and Human Services be required to issue regulations, so that implementation can be assured.

Although New York State's three-year waiver from the Health Care Financing Administration (HCFA) permits us to implement our own statewide system of prospective reimbursement under Medicare, we believe the resolution of this issue will establish an important precedent which will have profound consequences for us and for all public and inner city hospitals far into the future.

Over the past few months, we have working with the Administration in order to develop guidelines that could be used to implement the adjustment permitted under Section 101. In addition, it was anticipated that our efforts would be used as a basis for adjustments in the newly proposed DRG methodology for prospective payment. However, in the Administration's propective payment proposal, it is noted on page 75 that "HCFA is planning to examine the extent to which certain groups of hospitals treat more costly cases within DRGs. However, no widely applicable method currently exists to make valid severity distinctions. In addition, data sets which could relect severity are not universally applicable. These could take five to ten years to develop to the point where they could support a national Medicare payment system. DRGs have the distinct advantage of being based on available data. Nevertheless severity is one dimension that may warrant further study."

We must admit some degree of frustration with this response. We are pleased that the Administration has at least acknowledged the possible need for further research. However, we do not believe we can wait, while the appropriate data sets are being developed. Our need for assistance will be far more immediate, if the Administration's proposal were to be implemented as described in the document released in December.

As I noted above, the findings of our two studies lead us to the inescapable conclusion that unless the DRG approach is modified to adequately reflect our more complex caseload, not only would we be under-reimbursed for the care we provide, but there would be an accelerated shifting of high-cost patients from private to public institutions.

Given current encomic conditions, we have no doubt that this would lead to further disparities between public and private institutions in their capacity to provide quality care. While New York State hospital cost increases have averaged 9.8 percent, HHC's have increased at 7 percent. This disparity has been due in large measure to the severe fiscal pressures on our city tax base. These continued pressures, combined with accelerated cost shifting would inevitably mean that those requiring the highest levels of care would be served by institutions most serioulv impacted by the system of reimbursement.

Let me now turn to the specific concerns that we have with the DRG method of classifying patients, in relation to our caseload. As developed by HCFA, DRG's group ases for purposes of reimbursement on the basis of the principle diagnosis; presence or absence of a secondary diagnosis; presence or absence of a surgical procedure; age and discharge status. It is proposed that hospitals would receive a flat amount per DGR, regardless of the costs they incur in actually treating particular patients, and regardless of the length of stay. A newly drafted provision of the legislation would modify this approach slightly, giving the Secretary of HHS discretion to provide an additional payment where the stay exceeds 30 days of the mean stay within a DRG.

This overall approach cause significant problems for us, since specific factors which are more prevalent in our hospitals and which are associated with the significantly higher costs are not taken into account. These factors include:

Multiple diagnoses—HCFA's proposed method of classification takes into account only two diagnoses. Yet fully 55 percent of our Medicare patients have three or more diagnoses. These patients require more intensive level of care and were shown to be the cause of our longer lengths of stay. Under the DRG system, length of stay is the single most costly factor in treating a patient.

Severity of disgnoses—Each DRG contains multiple diagnoses. We have found that in comparison with private facilites we have a greater proportion of diagnoses within DRGs which are associated with a greater severity of illness. One obvious example of this phenomenon is evidenced by our analysis of DRG 5 (original DRG developed by Yale New Haven). In this grouping of patients (which represents the medical diagnosis septicemia with and without surgery) nearly half (47 percent of the cases in our hospitals had a principle diagnosis of tuberculosis, which is associated with a longer more costly length of stay. In contrast, in voluntary hospitals, only one-fifth (19 percent) of the patients had tuberculosis.

Moreover, the proposed DGR system does not take into account the nature of the secondary diagnosis; it only records whether it is present. Yet in our hospitals, a secondary diagnosis can frequently be the cause of a much longer, costlier length of stay than indicated by the principle diagnosis alone.

We found numerous other examples indicating a more intensive level of care is required within DRGs in public hospitals. The intensity of care was in turn found to be closely associated with the following patient characteristics:

High proportion of emergency admissions.—Seventy-five percent of all our Medicare patients are admitted on an emergency basis. This has many costly implications not taken into account by HCFA's DRG system:

Intensity of illness.—Our emergency admissions are sicker than elective admissions. They account for approximately 70 percent of all HHC patients admitted with three or more diagnoses.

Length of stay.—Emergency admissions stay longer than elective admissions. In HHC, hospitals that have "excess days" (days over a predetermined standard per diagnosis), emergency admissions invariably account for 90 to 100 percent of the excess. This is not only because they are sicker, but because they lack prior medical records and pre-admission testing which would otherwise reduce their hospital stay.

Increased staffing needs.—High proportions of emergency admissions, particularly those involving unscheduled surgery, require a hospital to maintain peak staffing patterns at all times, even though they may not be fully utilized.

Income level.—National surveys have consistently found that hospital stays differ by as much as 40 percent for poor patients. The proportion of cases with uniquely long lengths of stay (using the New Jersey trim points) in our hospitals average roughly twice the rate of that in the region's voluntary hospitals. The proportion of "outliers" at Bellevue is over twice that found among 25 teaching hospitals by a Yale-New Haven study and is almost twice the proportion found in five major New York City teaching hospitals—despite the fact that these cases had a 95 percent PSRO approval rate.

Significant need for alternative level of care.—Many of our patients require an alternate level of care following their acute care episodes. However, shortages of nursing home beds coupled with problems that often arise when attempting to place poor patients in alternate care facilities lead to extended stays in our hospitals. The situation is particularly acute for Medicare patients who accounted for 57 percent of our alternate level of care cases in 1980.

How should the current proposal be modified to address these differences in patient mix? We would suggest three specific approaches:

First, the development of an adjustment specifically tailored to meet the needs of hospitals serving a more complex caseload. As indicated earlier in the Report to Congress on Hospital Prospective Payment for Medicare: "HFCA is planning to examine the extent to which certain groups of hospitals treat more costly cases within DRGs." Our Corporation is working with the National Association of Public Hospitals and HCFA to address the issue. We hope to have additional data in time to meet the needs of this Committee. Specifically, we will propose that adjustments be computed, which give appropriate weight to those factors which public hospital "outliers" have in common. These include: emergency room admissions, multiple diagnoses, mix of diagnoses within a DRG, discharge status, and payor status. Such adjustments would permit the DRGs to reflect the case mix in public hospitals and ensure equitable treatment under a reimbursement plan which utilized DRGs.

Second, by including an allowance for bad debt and charity care, to spread the cost of serving indigent patients in relation to the cost of such care provided. Such an allowance was just included in the New York State rate, which represents a significant step forward, particularly in recognizing the needs of the private sector to compensate for legitimate revenue shortfalls.

In addition we would recommend the following provisions, to address a number of other concerns we have with the proposal:

A requirement that the existing system be reviewed after a specific period of time, to assure the implementation of needed changes in the future;

The inclusion of an appeals process. In light of the sweeping changes that are being proposed, it seems unrealistic to develop a system without this added flexibility.

The inclusion of explicit incentives for further state experimentation in rate-setting, or the removal of disincentives. The Administration's draft proposal merely permits such experiments to continue. Meanwhile, HCFA is now requiring that all future waivers require DRG-based systems, and under waiver, NYS is required to operate its Medicare prospective system at 1½ percent below national trend. Certainly there will be less incentive for state experiments in the future, given such restrictions.

Finally, we strongly urge this Committee to take the time that is needed to assure that adequate consideration is given to the many important issues raised by the Administration's proposed system. While we support the effort to develop a national prospective payment system in an expeditious manner, we do not believe it is possible to consider this important proposal in the same time frame as the Social Security reform package.

Given the experience we have had in New York, we believe the elements we have outlined are essential to protect the future viability of our institutions. We literally cannot afford to do less.

NEW YORK CITY HEALTH AND HOSPITALS CORP.,
New York, N.Y., February 23, 1983.

CAROLYNE K. DAVIS, Ph. D.
Administrator, Department of Health and Human Services,
Health Care Financing Administration,
Washington, D.C.

DEAR DR. DAVIS: I am writing in response to the letter which I received recently from Ms. Patrice Hirsch Feinstein of your staff regarding studies which I sent to you that reveal serious problems in the impact of Diagnostic Related Groups (DRGs) on public hospitals. I have reviewed the conclusions reached by you carefully and would like to offer several further observations.

Your staff indicated that it is unclear whether the outlier experiences under the original DRG scheme will be repeated under the new DRGs or HCFA's Medicare DRGs. Unquestionably, the outlier experience will change as the definition of trim points used to determine outliers changes. However, this does not negate the fundamental finding in the Merrill/Schwartz study which demonstrated that public hospitals have a larger proportion of atypical cases when compared to the expected length-of-stay.

Your staff also suggested that it is unclear whether the Medicare cases had the same patterns of outliers as total cases data from all payors. The following supplemental data taken from data collected by Merrill/Schwartz but not included in the final report shows that the number of outliers for Medicare cases is a much greater percentage of cases than the percentage of total cases which are outliers.

COMPARISON OF OUTLIERS: MEDICARE VERSUS TOTAL CASES [1]

DRG's	Percent of medicare cases which are outliers	ALOS	Percent of total cases which are outliers
DRG's 6—Infectious disease with surgery:			
HHC [2]	29	68	18
Non-HHC	15	38	5
DRG 11—Cancer of the GI system with surgery:			
HHC	17	43	14
Non-HHC	3.4	26	3
DRG 142—CVA:			
HHC	31	40	30
Non-HHC	16	27	17
DRG 145—Circulatory dysfunction in brain with surgery:			
HHC	40	70.5	31
Non-HHC	14	39	10

[1] This is a partial listing. We would be pleased to provide an additional data set at your request.

[2] HHC—New York City Health and Hospitals Corp.

With respect to source of admission, we recognize that admitting practices through emergency rooms vary greatly among hospitals. However, we believe that source of admission can serve as an adjustment variable if appropriate crteria are developed and would be pleased to work with you in the formulation of such criteria. In addition, your staff suggested that because Medicare patient volumes are higher in public hospitals, such hospitals are better protectd by the "law of large numbers" from random variation by case type than are hospitals with few Medicare admissions. Data indicates that the Medicare patient volumes in urban public hospitals is not higher than voluntary hospitals. For exampe, a report published recently by the National Center for Health Services Resarch (Patients in Public General Hospitals: Are they Poorer and Sicker) shows that the proportion of revenues from Medicare patients in public hospitals located in SMSAs is 22.3 percent in comparison to 28.8 percent for voluntary hospitals in the same regions. Morever, the "law of large numbers" works against public hospitals because, as the Merrill/Shwartz study demonstrated public hospitals tend to care for patients with more complex diagnoses within DRGs.

With respect to payor type the Merrill/Shwarts study, like the Bellevue Length-of-Stay Appeal, include Alternate Level of Care days in the length-of-stay computation. It is important to include these days because they affect length-of-stay insofar as they reflect the difficult placement problems confronting many Medicaid patients.

With regard to dischange status, the following supplemental data taken from data collected by Merrill/Shwartz but not included in the final report shows that a higher proportion of outlines were associated with cases transferred from HHC facilities than those transferred from non-HHC facilities. The longer lengths-of-stay experienced by these cases lead to higher costs for care.

COMPARISON OF TRANSFERRED CASES: HHC VERSUS NON-HHC[1]

DRG	Number of cases transferred	ALOS[2]	Number of outlier total cases transferred
DRG 142-CVA:			
HHC	58	85	41
Non-HHC	58	46	21
DRG 311—Sterility:			
HHC	201	19.4	85
Non-HHc	0	[3] 0	0

[1] Tis is a partial listing. We would be pleased to provide additional data at your request.

[2] ALOS for transfer cases.

[3] ALOS for the nontransfer cases.

In terms of multiple diagnoses, your staff suggests that the HHC finding of more cases with multiple diagnoses does not conflict with the HCFA DRG approach. You indicate that the HCFA DRGs and case mix index take multiple diagnoses into account when classifying cases. The HCFA DRG system accounts only for the presence or absence of a second diagnosis and procedure. Many of our patients suffer from three or more diagnoses which, by definition, make them sicker and more difficult to treat. The Health and Hospitals Corporation recently analyzed SPARCS (Statewide Planning and Research Cooperative Systems) data and found that 27 percent of all cases in HHC facilities in 1980 had three or more diagnoses while fully 55.5 percent of all Medicare cases had three or more diagnoses. The HCFA DRGs, like all other DRG systems, are not sensitive enough to take into consideration severity-of-illness. Consequently, I believe this unfairly discriminates against public hospitals since they treat a substantial proportion of patients with more than two diagnoses.

Finally, with repect to your comments about mix of diagnoses, we remain seriously concerned about the impact of the distribution of cases within DRGs, (the so-called within DRG effect). The attached chart taken from the Merrill/Shwartz report shows that the impact of the within-DRG effect on length-of-stay is highly signficant. I am aware that your cost data does not indicate any measurable difference in costs between inner-city public hospitals and comparable hospitals, but this is attributable to the depressed budgets which public hospitals have had to live with for many years and not resource requirements. To perpetuate this inequitable fiscal situation is unfair to public hospitals and the patients they serve.

Thank you for the opportunity to provide you with this additional information. I look forward to continuing to work with you closely on these vital issues. If you need any further information, please do not hositate to contact me.

Sincerely,

Madeline A. Bohman,
Executive Director, Bellevue Hospital Center,
Vice-Chairman, National Association of Public Hospitals.

ATTACHMENT.— COMPONENT OF THE DIFFERENCE IN LENGTH OF STAY BETWEEN MUNICIPAL AND NONMUNICIPAL HOSPITALS FOR DIFFERENT SETS OF DRG's

Hospital Grouping	Difference LOS [1]	Case mix effect	Within-DRG effect
All DRG's:			
All hospitals	−0.06	−1.19	1.13
Teaching hospitals	0.44	−1.04	1.48
Nonteaching hospitals	−1.16	−1.61	0.45
Major surgery DRG's			
All hospitals	3.58	−0.93	4.56
Teaching hospitals	3.89	−1.15	5.04
Nonteaching hospitals	2.96	0.40	3.36
DRG's with secondary diagnoses:			
All hospitals	−1.36	−2.32	1.02
Teaching hospitals	−1.24	−2.55	1.31
Nonteaching hospitals	−1.47	−1.94	.47

[1] Length of stay in municipal hospitals minus length of stay in non-municipals.

Health and Hospitals Corp.,
Bellevue Hospital Center,
New York, N.Y., October 6, 1982.

Carolyne K. Davis, Ph. D.,
Administrator, U.S. Department of Health and Human Services,
Health Care Financing Administration,
Washington, D.C.

Dear Dr. Davis: On behalf of the National Association of Public Hospitals, may I thank you for the opportunity to meet with you recently to discuss the special requirements of public hospitals in relation to the utilization of a case mix system within a prospective reimbursement plan.

Enclosed for your review is followup information which discusses the weaknesses of Diagnosis Related Groups when applied to public hospitals. As Harriet Dronska, Vice-President of the New York City Health and Hospitals Corporation (HHC), described during the September 29 meeting, two studies conducted by HHC indicate that public hospitals have a greater proportion of outliers than voluntary hospitals. This is attributable to:

Source of admission—81 percent of HHC admissions were emergency room admissions compared to 25 percent in voluntary hospitals. Within this group, 94 percent of HHC teaching hospital outliers were emergency admissions versus 58 percent in non-HHC teaching hospitals;

Payor type—public hospitals serve greater numbers of Medicaid patients who often require a longer length of stay due to poor medical conditions associated with low socio-economic status;

Discharge status—public hospitals serve greater numbers of patients requiring transfer to a non-acute facility because they are homeless or have no families who can provide necessary post-hospital care;

Multiple diagnoses—public hospitals serve large numbers of patients with multiple diagnoses requiring longer lengths of stay; and

Mix of diagnoses—each DRG contains a variety of different diagnoses some of which are more complex than others. Public hospitals have a greater concentration of more complex diagnoses within discrete DRGs. For example, within DRG 5 (Septicemia with and without surgery), 47 percent of the cases in the HHC hospital had tuberculosis while only 19 percent had tuberculosis in the voluntary hospitals.

I hope this information is helpful. Please be assured that we are available to work closely with you and your staff to develop adjustments which are needed to compensate for these weaknesses. Again, thank you for your time. I look forward to working with you on this critical matter.

Sincerely,

MADELINE A. BOHMAN,
Executive Director, Bellevue Hospital Center,
Vice-Chairman, National Association of Public Hospitals.

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Washington, D.C., December 23, 1982.

MS. MADELNE A. BOHMAN,
Executive Director, Bellevue Hospital Center,
New York, N.Y.

DEAR MS. BOHMAN: Dr. Carolyne K. Davis has asked that I respond to your letter sending the additional information concerning public hospital's case mix. Thank you for providing these materials.

After reviewing the material, my staff has made several general observations:

It is not clear that the outlier experiences under the older DRG scheme will be repeated to the same extent under the newer DRG system or HCFA's Medicare version of it.

Likewise, it is not immediately clear whether the Medicare cases had the same patterns of "outliers" as the total cases data from all payers.

The New York City Health and Hospitals Corporation (HHC) study does not indicate how "outliers" were defined for purposes of the research.

On the specific points cited in your letter:

1. Source of admission

We may not be able to generalize from the findings that HHC experienced more admissions through emergency rooms, because admitting practices vary so greatly among hospitals. We might quarrel with some of the HHC study assertions about which case types are "less predictable" DRGs (for example "infectious diseases" and "injuries"). In the main, we believe that because their Medicare patient volumes are higher, public hospitals are better protected by the "law of large numbers" from random variation by case type than are hospitals with few Medicare admissions.

2. Payor type

We cannot readily assess your "payor type" conclusion that Medicaid patients more often require a longer length of stay. The HHC study did not indicate that "Alternate Level of Care Days" (an important point in the Bellevue Appeal) were included in the lengths of stay computations.

3. Discharge status

While as HHC experience suggests, public hospitals may have more patients discharged to other institutions, we have no evidence that acute care costs before live discharge are affected by the discharge status.

4. Multiple diagnoses

The HHC finding of more cases with multiple diagnoses does not conflict with our DRG approach. our DRGs and case-mix index take multiple diagnoses into account when classifying cases.

5. Mix of diagnoses

Although the HHC study suggests that public hospitals have more complex cases within DRGs, our assessments to date show that the expected impact of Medicare total cost limits upon "large urban (inner city) public hospitals" is not markedly different than the impact upon other types of hospitals. But we have not ruled out the possibility that in some DRGs, pubic hospitals may treat more severely ill patients.

The finding of a more concentrated caseload in HHC hospitals would not invalidate the Medicare DRG relative weights or rates. In fact, if economies of scale exist, public hospitals could benefit. We are still examining the reimbursement issues associated with "outliers" including their programmatic definition, but, in our research to date using statistical definitions we observed no unusual concentration of outlier cases in public hospitals.

In summary, we have uncovered no evidence thus far which conclusively suggests that the Medicare case-mix index fails to adequately reflect differences in the Medicare patients treated in public hospitals. However, we will continue to examine our data to determine if there is evidence that public hospital Medicare patients overall or for particular DRG's are different from other Medicare inpatients in ways which could lead to deficient Medicare payments to public hospitals.

Please continue to provide us with additional information or studies you may have on these important matters. I truly appreciate your taking the time and effort to work with us.

Sincerely yours,

PATRICE HIRSCH FEINSTEIN,
Associate Administrator for Policy.

CASE MIX MEASURES AND PUBLIC HOSPITALS, ANALYSES BY THE NEW YORK CITY HEALTH AND HOSPITALS CORP.

OVERVIEW

Introduction

The introduction of Diagnosis Related Groups in the health care system represents an important development in the management of hospitals. DRGs provide a useful management and planning tool for institutions and may be particularly effective as a cost containment mechanism. Weaknesses in the DRG system with respect to severity of illness and multiple diagnoses (beyond major or minor secondary diagnoses) prevent DRGs from providing an adequate reflection of the case mix in public hospitals. As the following discussion will indicate, any formula which utilizes the application of DRGs for hospital reimbursement purposes must be adjusted for public hospitals in order to account for the special characteristics of their case mix and provide equitable treatment under a payment plan.

Two studies recently conducted by the New York City Health and Hospitals Corporation (HHC) point out the weaknesses of the DRG classification system when applied to public hospitals. These are 1) The Bellevue Hospital Center 1982 Medicaid Length of Stay Appeal and 2) "The Impact of Case Mix Measures on HHC Hospitals: An Analysis" prepared by Jeffrey Merrill and Michael Shwartz. The first was prepared by Bellevue Hospital for New York State in response to a length of stay penalty imposed on the hospital's 1982 Medicaid rate for days of care provided in 1980 judged by the State (utilizing a case mix measurement system) to be in excess of allowable lenghts of stay. The second was conducted under contract from HHC by the investigators utilizing 1979 data to determine the impact of case mix measures on HHC hospitals in comparison to other, similar voluntary hospitals.

In general, these studies found that:

DRGs are inadequate to describe a significant proportion of cases in public hospitals:

Such case, which become "outliers", are disproportionately prevalent in public hospitals; and

Similar characteristics involving payor type, source of admission, and multiple diagnoses are common to these outliers.

Discussion

Both studies (Merrill-Shwartz and Bellevue) found that public hospitals have a higher proportion of outliers than comparison goups.

OUTLIERS AS A PERCENT OF DISCHARGES[1]

HHC hospitals	HHC	Non-HHC
Bronx Municipal	5.8	3.9
Lincoln	5.3	3.0
North Central Bronx	4.0	1.7
Coney Island	3.5	3.3
Cumberland[2]	3.0	3.1
Greenpoint[2]	3.2	3.2
Kings County	5.0	3.9
Bellevue	6.9	3.9
Harlem	7.1	3.8
Metropolitan	5.2	3.8
Elmhurst	4.6	3.8
Queens	3.7	2.4

[1] Merrill Shwartz, page 31, table 17.
[2] These hospitals are slated for closure in fiscal year 1983.

The Bellevue study found:

In 1980, outlier cases accounted for 7.7 percent of Bellevue discharges and 39.3 percent of discharge days.

Bellevue's proportions are over twice those found in a study of 25 major teaching hospitals conducted by Yale-New Haven Hospital. In that study, outlier cases accounted for 3.4 percent of discharges and 17.7 percent of discharge days.

Bellevue had almost twice as many outliers as five major teaching hospitals in New York City in 1978. On the average, 4.4 percent of total cases and 30.8 percent of discharge days were outliers in the other teaching hospitals.

The following table shows that Bellevue had substantially higher proportions of outlier cases and outlier days and a longer outlier length of stay in 1980 than did four other major teaching hospitals in New York City.

PROPORTION OF OUTLIERS AT BELLEVUE AND OTHER MAJOR NEW YORK CITY TEACHING HOSPITALS IN 1980

Hospital name	Outlier cases as a percent of total	Outlier days as a percent of total	Outlier average length of stay
New York-Cornell	4.4	NA	33.6
St. Vincent's	5.2	26.5	54.5
Mount Sinai	5.3	21.8	46.5
Long Island Jewish (LIJ Unit)	3.6	14.8	38.4
Bellevue Hospital	7.7	39.3	65.2

Substantiating that the length of stay associated with these outlier cases was, in fact, due to medical necessity and not inefficiency is critically important. Using PSRO approvals as a proxy for determining medical need, Bellevue found that its outlier cases represented a 95 percent PSRO approval rate. This high rate of validation by PSRO coupled with the proportion of outlier cases in public hospitals supports the conclusion that public hospitals serve sicker patients in greater numbers.

The Merrill-Shwartz study found that the case mix in public hospitals is concentrated in fewer and less complex DRGs than voluntary hospitals. (See Tables 5 and 6, pages 16 and 17, table 7, pages 19-20, Merrill-Shwartz study). This conclusion requires reconfirmation with more recent data, since coding practices in 1979 may have been seriously deficient in relation to the comparison groups. Under any circumstances, three observations are in order:

(1) Merrill-Shwartz discovered that within discrete DRGs, municipal hospitals have a greater concentration of more complex cases. This is attributable to the fact that each DRG includes a variety of different diagnoses, some of which are more complex than others. For example, within DRG 5 (Septicemia with and without surgery), 47 percent of the cases in HHC hospitals had tuberculosis while only 19 percent of the cases in the voluntary hospitals had tuberculosis. Tuberculosis has a longer length of stay[1] Another example can be seen in DRG 77 (Diabetes). 71 percent of the HHC cases had adult diabetes compared to 59 percent in the voluntary hospitals. Adult diabetes has a long length of stay, generally 70 days. Moreover, 1½ percent of the diabetes cases in HHC hospitals were related to ophthalmological problems as contrasted to 24 percent in the non-HHC hospitals. These cases are associated with a short length of stay of 4.3 days. Thus, within DRGs, the case mix complexity varies significantly between public and voluntary hospitals and may account for much of the difference in the proportion of outliers between the two groups.

(2) Merrill-Shwartz found that the voluntary hospitals experience a substantially greater number of surgical cases than the HHC facilities. (16.7 percent of all discharges in voluntary hospitals versus 8.3 percent in HHC facilities. See table 8, page 21, Merrill-Shwartz study). Under the DRG system, this would suggest that voluntary hospitals have a more complex case mix because DRGs define the presence of surgery in a case as a more complex case. However, this is misleading. The difference in the prevalence of surgical procedures between the two groups is attributable to the fact that voluntary hospitals perform significantly more elective or non-emergent surgery—procedures generally associated with short lengths-of-stay. Therefore, the presence or absence of surgery does not alone define severity of illness or case

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[1] See also the discussion of severity of illness of tuberculosis patients, page 23 of the Bellevue study.

mix complexity and may have little to do with an institution's performance respecting length of stay.

(3) The DRG classification system is not flexible enough to account for new technologies which may replace surgical procedures but still have associated costs which are greater than the assigned DRG without surgery. An example of this is a newly developed procedure called invasive radiography. This technique, which is invasive but not surgical, utilizes special needles and catheters to drain internal abscesses.

CHARACTERISTICS WHICH OUTLIERS HAVE IN COMMON

The examination of the characteristics of outlier cases reveals significant commonalities:

(1) Admission source.—Bellevue and Merrill-Shwartz found that a significant proportion of outlier cases were emergency room admissions. As would be expected, ER admissions have a greater severity of illness. Bellevue found that the length of stay of ER admissions is nearly twice that of elective admissions. (14.7 days to 8.4 days). More importantly, Bellevue found that 90 percent of their excess days, or days for which the hospital was being penalized, were associated with ER admissions. (See page 28 of the Bellevue study.) Merrill-Shwartz examined DRGs to determine the influence of admission source and found that in 56 percent of the DRGs reviewed, emergency admissions had a significantly higher length of stay than elective admissions. In 24 percent of the discharges, the opposite occurred (see page 43, Merrill-Shwartz report).

(2) Discharge status.—Merrill-Shwartz found that discharge status plays an important role in determining length of stay. One variable, transfer to a non-acute facility, accounts for significant difference in length of stay between public and voluntary hospitals. In general, a greater percentage of patients in HHC facilities are transferred to a non-acute facility than in the voluntary hospitals. This may be attributable to severity of illness and domicile status (this refers to whether or not the patient has home or family members who can assist in necessary post-hospital care). Merrill-Shwartz found that transfer patients generally have a longer length-of-stay, and that there are greater numbers of such patients in public hospitals which contributes to larger numbers of outlier cases (see page 39, Merrill-Shwartz).

(3) Payor type.—Merrill-Shwartz analyzed the impact of payor type on differences in length of stay and found that Medicaid patients tend to have a longer length of stay than Blue Cross or other private payor patients. (see pages 34–38, Merrill-Shwartz study). This is the case because Medicaid patients are from lower socio-economic levels which are associated with poor health conditions.[2] The length-of-stay experience of Medicaid patients is significant because Medicaid patients comprise a larger proportion of the patient population in public hospitals.

(4) Multiple diagnoses.—The DRG classification system accounts for primary and secondary diagnoses. This is inadequate to reflect the medical condition of many public hospital patients. The following chart represents an analysis of Bellevue's 1980 discharge data (pg. 29, Bellevue, study).

BELLEVUE HOSPITAL CENTER: ANALYSIS OF DIAGNOSES PER CASE—1980[1]

No. DX/case	Percent of all cases	Percent of excess days
1	33	−9
2	27	−34
3	17	1
4	11	29
5	13	112
	100	100

[1] Page 29, Bellevue study.

The findings of this analysis are significant: First, the analysis reveals that 41 percent of all cases had 3–5 diagnoses. Second, in the aggregate, those cases with 3–5 diagnoses represented the cause of the excess days. This demonstrates that patients with multiple diagnoses have a greater severity of illness and can be expected to require a longer length of stay than that which is allowed by the assigned DRG.

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[2] See discussion of socio-economic status, pg. 29 of the Bellevue study.

(5) Within DRG mix of diagnoses.—As indicated previously, Merrill-Shwartz found that within discrete DRGs municipal hospitals have a greater concentration of more complex cases. In general, cases which become outliers are those which represent the most complex diagnoses within a DRG.

CONCLUSIONS AND RECOMMENDATIONS

Based on the preceding discussion, it can be concluded that the DRG classification system is inadequate to accurately reflect the patient mix in public hospitals. Because of identified deficiencies, public hospitals experience greater proportions of outliers than their voluntary counterparts. Accordingly, adjustments must be made to correct for the system's deficiencies if DRGs are to be used for calculating institutional reimbursement. In this regard, it is proposed that adjustments be computed which give appropriate weight to those factors which public hospital outliers have in common.

These include: emergency room admissions, multiple diagnoses, mix of diagnoses within a DRG, discharge status, and payor status (representing a proxy for socioeconomic factors). Such adjustments would permit the DRGs to better reflect the case mix in public hospitals and ensure equitable treatment under a reimbursement plan which utilizes DRGs.

STATEMENT OF RITA RICARDO-CAMBELL, STANFORD, CALIF.

THE RX FOR HEALTH CARE: THE PRESIDENT'S HEALTH REFORM PACKAGE

GOVERNMENT PRICE FIXING IS NO SOLUTION

A multiprong reform bill to contain medical care costs in the government programs of Medicare and Medicaid and under private health insurance is being pushed through Congress with minimal hearings.

Medical care prices have been rising at double the rate of the Consumer Price Index and the health sector's share of the gross national product has been rising at 1 percent in each of the last three years: 9 percent to 10 percent to 11 percent in 1983. A crisis orientation prevails. Health and Human Services Secretary Richard Schweiker testified prior to his departure so that the new secretary, who has little knowledge about this sector of the economy, would not have to testify for this far-reaching reform package. Medicare cannot live with annual cost increases of 18 percent to 21.5 percent. Medicare pays out about three-fourths of its monies to hospitals.

It is easier to control payments to about 8,000 hospitals than to more than 300,000 physicians. Thus, a Medicare prospective payment plan for hospitals based on 467 Diagnosis-Related Groups (DRG) and patterned after New Jersey's experience is being sold as effective cost-containment. Each of the 467 flat rates based on the primary diagnosis would be modified by a specially constructed index of hospital labor-costs in a given area.

Leading the list of indices for 300 "urban areas" is Vallejo-Fairfield-Napa, California, with a wage index value of 1.6758. Among the 10 highest are five other California areas and these do not include the large cities of Los Angeles, San Jose and San Diego. In the 10 highest labor cost urban areas are Santa Rosa and Visalia-Tulare-Porterville. These special indices do no reflect only an area's average labor costs. Wages are not higher in Santa Rosa and Tulare than in Los Angeles or San Francisco. The use of such modifiers freezes the existing geographical relationships of the factors in the index and destroys the incentive for labor to move where pay is higher.

The 467 DRG rates, modified also by age, would not reflect either teaching costs of university hospitals or capital costs of any hospitals. These costs would be reimbursed as "pass-throughs." The proposal is not expected to save money in the near future than under the present system. The president of the American Hospital Association has stated that hospitals can keep their annual rise in costs to 10 percent or 11 percent not by more efficiency but providing "less convenience for doctors and patients and nurses and administrators."

The proposal would set thousands of rates, not 467, that would require an army of bureaucrats to administer. It is a bureaucratic nightmare. Most elderly persons who are admitted to a hospital have more than one health problem. Thus, a physician makes several diagnoses and reimbursement may be requested for the most profitable diagnosis among several. Who is going to argue whether the physician filed for the actual primary diagnosis or the highest dollar-yielding diagnosis? The result of playing this game is DRG "creep." Sampling of claims to control the game could be expensive. Even if errors are believed to be found, what bureaucrat would be qualified to make the needed medical distinctions? The bureaucrat will not have seen the patient. How will the bureaucrat argue with a physician who has taken care of the patient?

New Jersey's experience with this system is not reassuring. Its marginal hospital admissions appear to have increased sufficiently to negate the cost-effectiveness derived from an induced lower number of hospital days for each patient. With a set case rate a hospital makes more money the fewer the hospital days per patient and the fewer the services provided. How the quality of care is protected in the face of these new economic incentives is not spelled out. The incentive to increase hospital admissions that may not be medically necessary is high. The hospital is paid per case. Any admission will do. Although New Jersey sets payment levels for all patients the administration's plan would apply to only Medicare patients. Thus, hospitals would continue to subsidize government patients from private-paying patients.

The 26 hospitals in New Jersey which were on a DRG basis had a 13.1 percent annual increase in 1980, while the other New Jersey hospitals had a 13.8 percent increase. This is not a statistically significant difference, it could have happened by chance. New Jersey hospitals that were making money increased their costs by 14.1 percent; while those losing money did so by 10.1 percent. How hospitals do and how much money government saves depends on the level at which DRG rates are set. Many top administrators of the Department of Health and Human Services are physicians. There is a considerable degree of arbitrary judgment in setting the level of DRGs.

President Reagan is against government regulation. Yet this reform proposal implies that government will set thousand of prices. The health policy reform package does contain two of the president's long-held ideas: to structure Medicare to be truly catastrophic health expense coverage with no co-payments after the 60th hospital day and to issue on a voluntary basis cash vouchers for Medicare beneficiaries to purchase a private health plan rather than using Medicare's plan.

Although the latter proposal is expected to save at most only $50 million a year, it is a first step toward more competitive health care markets, as is the requirement for competitive bidding for laboratory services.

If vouchers are to be successful, however, the consumer must have information about the prices of health insurance, medical care services and various prepaid group arrangements. Knowledge of the "usual, customary and reasonable" (UCR) charge by a physician in relationship to the Medicare reimbursed charge, would inform Medicare patients about the dollar amounts for which they are still responsible after the government has made its payment. Prudent pruchasers should also know about provider arrangements that may limit their access to specialists, and they need to have some way of judging quality. The reform proposal says nothing about the informational requirements of competitive markets.

The package's major money raiser, about $33 billion over a five-year period, would require individuals to pay personal income tax on the amount of health insurance premium paid by their employers above $174 per month, or $2,100 a year if "a family," and above $70 a month or only $840 a year if an individual. The concept is to restrain demand for medical care indirectly by discouraging employers from including in the employee's wage package expensive, first-dollar health insurance coverage. This is a worthy goal toward which many employers have already moved. Less than 30 percent of employers are providing first-dollar coverage today as compared to 45 percent in 1979. I support the concept, but I quarrel with the tax inequity created for some individuals by setting $70, rather $87.50 per month (one-half the amount set for the family) as the individual tax-free premium. Insurers set family health insurance premiums at more than twice the individual rate in order to meet the actuarial costs of medical care for children. The government, however, is a tax collector and not an insurer.

Economists agree that a major cause of the rapid escalation in health costs lies in these extensive, third party payments for medical care. Because the proposed tax-free limits are not indexed, most employees covered by health insurance would eventually be affected. Because of the large revenue yield, this is a tempting proposal for those facing a budget deficit.

STATEMENT OF LAWRENCE G. CROWLEY, M.D., PRESIDENT, STANFORD UNIVERSITY HOSPITAL

HOSPITAL PROSPECTIVE PAYMENT FOR MEDICARE—DHHS PROPOSAL

This letter is to express certain concerns regarding the Department of Health and Human Services (DHHS) recent proposal to Congress on "Hospital Prospective Payment for Medicare". The document describes the methodology and rationale for the Administration's proposed Medicare prospective payment system, the key feature of which is to categorize each Medicare case into one of 467 "Diagnostic Related Groups (DRGs) and to reimburse a fixed amount per case based on the DRG.

We agree that the Administration's proposal is, in the main, well researched, may be effective in restraining the growth of hospital costs, and is a vast improvement over the present single rate-per-case reimbursement system. Nevertheless, we believe the system, because it uses the principle of averaging within a DRG, has the potential to over-reimburse many hopitals that treat a less severly ill mix of patients and under-reimburse those hospitals that, because of their unique programs and resources, treat a high proportion of the most severely ill patients.

The idea behind the DRG methodology is that cases within each DRG require, on the average, about the same utilization of medical resources and hence cost. However, within each DRG there are sizeable differences in the severity (and costliness) of individual illnesses treated. HCFA recognizes this limitation, and provides for special treatment for cases which are clearly atypical of the average case in a DRG. However, this provision is limited to only 0.5 percent of all cases. Furthermore, HCFA admits the likelihood that teaching hospitals treat the more severely ill within many DRGs, and proposes to account for this difference through an unspecified addded payment for "indirect teaching costs". We believe that unless care is taken to ensure that the proposed payment for "indirect teaching costs" fully accounts for difference in severity of illness treated within DRGs, the system will penalize most teaching hospitals which treat a disproportionate share of the most severely ill patients.

Numerous studies have found a direct correlation between severity of illness and resource utilization, as oppposed to the report's statement that ". . . the degree of severity of illness is not uniformly associated with treatment cost per case." Studies have shown that 50-50 percent of the variation in charges (and therefore, cost) within a DRG is explained by severity of illness.[1] Therefore, a severity of illness measure, when combined with DRGs, would be superior to DRGs used alone in defining groups of cases which should be reimbursed like amounts.

We recognize that to provide for differences in severity of illness would be difficult in a reimbursement mechanism that can be applied on a large scale with a large number of providers. The DRG methodology has been generally proven to be a reasonably good (but imperfect) indicator of resource utilization and easy to apply. However, because it does no properly account for the resource utilization of highly severe cases within DRGs, the system may severely penalize those hospitals that treat a high proportion of highly severe cases. We thus suggest that the three following provisions be included in the proposed plan:

(1) Provide for exceptions to the DRG rates based on demonstrated dfferences in severity.

(2) HCFA be mandated to continue study of a methodology which fully accounts for severity of illness.

(3) Specific language with respect to the adjustment for the indirect costs of medical education to make explicit that it will be no less than provided in the present Section 223 per-case limit.

We would appreciate your assistance as a member of the Subcommittee on Health of the House Ways and Means Committee to consider the above recommendations in your deliberations of the Administration's proposal.

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[1] Reference: Horn, S.D. and Sharkey, P.D., "Measuring Severity of Illness: Predicting Hospital Total Charges Length of Stay and Ancillary Charges." Technical Report, Center for Hospital Finance and Management, The Johns Hopkins University, Baltimore, Md., October, 1982.

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